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Mentally Retarded and Normal Children

A comparative study of their family conditions

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Preface

Mental retardation is a worldwide problem and in India it is estimated that about 1.5 to 1.8 million children of the age group of 6 to 14 years are mentally retarded. Mental retardation is not only a biological, educational or psychological problem but it is a multi-dimensional problem of a mixture of psycho-social, biological and educational factor. But the public and professional interest in the etiology of mental retardation and in the problems faced by retarded children and their families has been at best meagre and sporadic. This apathy has persisted despite the high incidence of mental subnormality throughout the world, a problem which no society can avoid. Yet until recent years training schools and other public facilities have suffered from a general lack of attention, a lack of financial support and a lack of trained personnel. Probably no other public health problem of such enormity has been so blatantly neglected.

This study aims to find out the significant association of the background factors with the incidence of mental retardation in families under study. The family background constituent has been reduced to characteristics of the parents, caste and community, income and occupation, sibling order and other relevant factors of family history of the mentally retarded children. Here no causal design of findings has been established. The findings only revealed the concomitant relationship of two variables—the social conditions and mental retardation—as the research pools were not competent enough to establish causal relationship between these variables.

The study reveals that the importance of adequate social and cultural environment is an essential prerequisite for normal intellectual development of a child. The study further reveals that mental retardation is inversely related to the socio-economic status of the

children; marital status of the parents of such children are not healthy; mostly these children are unwanted and rejected by their parents; frequency of premature deaths of the parents are higher in the case of retarded children as compared to normal children; retarded children mostly come from joint families which are more vulnerable to internal conflicts and discord by their very nature.

Mental retardation, being such an important problem, it is felt that the present book will be useful to persons who are working in this field and for the parents who have a mentally retarded child in their family, and for those who are interested in this social problem.

MANJU BISWAS

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1

Introduction

Mental Retardation Defined

MENTAL retardation is incomplete mental development. The mentally retarded are those whose normal intellectual growth is arrested at some time before birth, during the birth process or in the early years of development. In more scientific terms, "Mental retardation refers to sub-average intellectual functioning which originate during the developmental period and is associated with impairment in adaptive behaviour".[1]

Because of their impaired ability to learn, mentally retarded persons usually have difficulty in meeting the needs of everyday living. However, the degree of adjustment as well as the ability to learn, varies widely with the degree of mental retardation.

Mental Deficiency Act of 1927 in Great Britain defined mental retardation as "a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury" (section 1, paragraph 2).[2]

Recently, the World Health Organization recommended the use of the term *mental subnormality* which in turn is divided into two separate and distinct categories : (i) Mental retardation, and (ii) Mental deficiency.

According to this nosology, mental retardation is reserved for subnormal functioning due to environmental causes in the absence of central nervous system pathology and mental deficiency describes subnormal functioning due to pathological causes. Mental deficiency is also used often as a legal term, applied to people with an IQ below 70.

Mental Retardation Classified

Mentally retarded children and adults can be grouped into four classes and they are:

(i) *Profound* (IQ 20 and below): These persons are often physically handicapped. They need constant care and supervision for survival.

(ii) *Severe* (IQ 20 to 35): Their motor development—speech, language are retarded and they are not completely dependent. They are often, but not always physically handicapped.

(iii) *Moderate* (IQ 35 to 50): They are backward in their development, but able to learn to care for themselves. Children capable of being trained. Adults need to work and live in sheltered environment.

(iv) *Mild* (IQ 50 to 70) : The development in this case is slow, and children are capable of being educated within limits. Adults with training, can work in competitive employment and are able to live independent lives.

Mental retardation is considered under the following criteria:[3]

(i) Psychometric criteria

(ii) Educational and Social criteria

(iii) Clinical criteria

(iv) Legal criteria

(i) *Psychometric Criteria*: Intelligence score is the measure of general ability. If the intelligence is lower than two standard deviations below the normal, the person is said to have retarded intelligence. People scoring less than 70 points IQ are retarded.

(ii) *Educational and Social Criteria*: Mentally subnormal people are socially inadequate. They cannot adapt themselves to the social order prevailing in the country. They are educationally subnormal or retarded. They are unable to derive any benefit from education in the ordinary school.

(iii) *Clinical Criteria*: Pathological type alongwith social and intellectual handicaps such as Mongolism and other rare conditions, as Gargoylism.

Others with delayed motor, social and intellectual functioning with or without pathological abnormalities (sub-culture types).

(iv) *Legal Criteria*: According to English Mental Health Act 1959, a patient is subnormal by reasons of arrested or incomplete

development of mind, which includes subnormality of intelligence. He requires or is susceptible to medical treatment or other special care or training.

Difference between Mental Retardation and Mental Illness

Mental retardation and mental illness are separate and distinct disorders. Mental illness is often temporary and reversible, and may strike off any time during the life of the individual. Mental illness can be treated and often cured.

Mental retardation, on the other hand, occurs during the period of development, or is present from birth or early childhood. It is a chronic and life-long condition, although it may be alleviated through special education, training, rehabilitation and proper care.

When the mentally retarded have difficulty in adjusting to the demands of society, the problem is usually related to limited intellectual capacity and the lack of understanding of what society expects of its members.

When the mentally ill fail to adjust to society's demands, it is often because their mental disorders have caused them to lose touch with reality, or their emotions interfere with so-called normal response. However, the mentally retarded can also have emotional problems and can become mentally ill.[4]

From Alliance with Devil to Welfare: Historical Survey

"The first terminal period in the field of mental retardation coincided with the time of the French and American Revolutions and the ideas of equality and rights for all men, which upset the feudal vertical social structure".[5]

The second period follows the revolution that swept in Europe in 1948, in the wake of which a further liberalisation of public opinion and gradually increasing legislative justice took place and special educational opportunities for the mentally retarded spread rapidly throughout Europe and North America.

The third, our present period, in turn followed the cataclysm of World War II, the great resurgence of professional and public interest in mental retardation.

Thus the social climate has been favourable for overcoming the traditional public inertia regarding mental illness and mental retardation.

Suddenly, the retarded were viewed as individuals with inherent needs and rights. In the United States, The National Association for Retarded Children founded in 1950 by groups of parents of retarded children, has been the prime motivator of the radical change in public opinion in favour of the retarded.

Early Attitudes

There is very little information about the problems of mental retardation in antiquity, in medieval times and even in the modern history. Up to the beginning of the 19th century we find only scanty references scattered among ancient religious and medical writings, indicating some awareness of the problem. In medieval Europe the mentally retarded were at best tolerated as jesters and freaks of nature and at worst, considered to be evil creatures in *alliance with the devil.* In contrast, religious leaders of Asia such as Confucius in China and Zoroaster in Persia, advocated human treatment of the mentally retarded in their teachings.

Mental retardation was often considered a variant of insanity and it was not until 1689 that Locke made a clear distinction between the two.

Nineteenth Century Attitude

The spirit of the French Revolution heralded the beginning of efforts to rectify all kinds of social injustices and to put an end to the sub-human treatment of the metally retarded.

In the middle of the 19th century, Guggenbiihl in Switzerland introduced the idea of institutional treatment of the mentally retarded.

The efforts of the medical profession during this period were largely diverted from fruitful research and were directed towards finding ways of checking the menace of mental retardation by various means of eugenic control, ranging from sterilisation to euthanasia and more recently, birth control.

Twentieth Century Attitudes

Several crucial discoveries may be credited to this period. One civilised country after another adopted new laws and introduced means to further research and ensure the welfare of the mentally retarded. To use a metaphor, mental retardation was the ugly maiden who was kept in the attic for a long time. Suddenly,

suitors have begun to arrive in numbers, since they discovered that the prospective bride is not so ugly after all and in addition, she now has a handsome dowry.

Mental Retardation as a Psychiatric and Sociological Problem

It was found that there was very little literature to cope with a social and health problem simultaneously.

The family in itself is an evolving social and cultural unit with a history, a life-style and a structure. Sociological studies were mostly directed to normal persons and groups and seldom to disordered persons. Sociologists found difficulty in gaining access to data in clinics and mental hospitals and social pressures within the discipline for a period led to the avoidance of the tragic and bizarre, as subjects of enquiry.

By the second decade of this century the sociologists had evolved a sophisticated theory for discerning the influence of social relationships upon personality.

Studies of mental hygiene and psychoses, neuroses and psychopathy pointed the way to an interesting area between sociology and psychiatry. But in the field of mental retardation this combination of views of psychiatrists and sociologists is rare. Most of the researches concerning mental subnormality were either conducted by the medical practitioners who naturally first concerned themselves with the cure of the disease, or purely by psychiatrists whose concerns were with the diagnosis, understanding and treatment of mental disease. Mostly, only after 1950, interdisciplinary studies of disordered and maladjusted behaviour have emerged between sociologists and psychiatrists, such as Srole, Hollingshead and Redlich, Sheila Hewett, G. Birch, Stephen A. Richardson, Sir Dugald Baird, Cordon Horbin Raymond *et al.* Epidemiological and correlational studies involved a division of labour in which the psychiatrists performed the diagnosis while the sociologists devised the research design.

Causal Diagnosis

A single egg from the mother, fertilized by a single sperm from the father and nurtured first within the mother and then within the family and the broader culture, develops during several decades into a mature human being, perhaps into a factory worker,

a house wife, or even a Lincoln or Gandhi. This miracle of development follows a set of specifications and a time-table which are a joint product of the individual's unique biological inheritance and the particular environment in which he lives. When we consider the complexity of the process, it seems incredible that anyone ever grows up to be a normal man or woman. Only a very small percentage of infants are born noticeably defective and the vast majority of those who are healthy at birth develop normally to maturity.

The causal factors have been presented in Chart 1. There is rarely a single cause or a simple explanation of any type of intellectual deficiency. In some cases, the retardation seems to be primarily a function of the hereditary endowment; in others, it seems to be the result of a complex interaction between genetic endowment and a multitude of environmental factors; and in still other cases, the retardation seems to be attributable to factors which are primarily environmental.

Genetic Factors

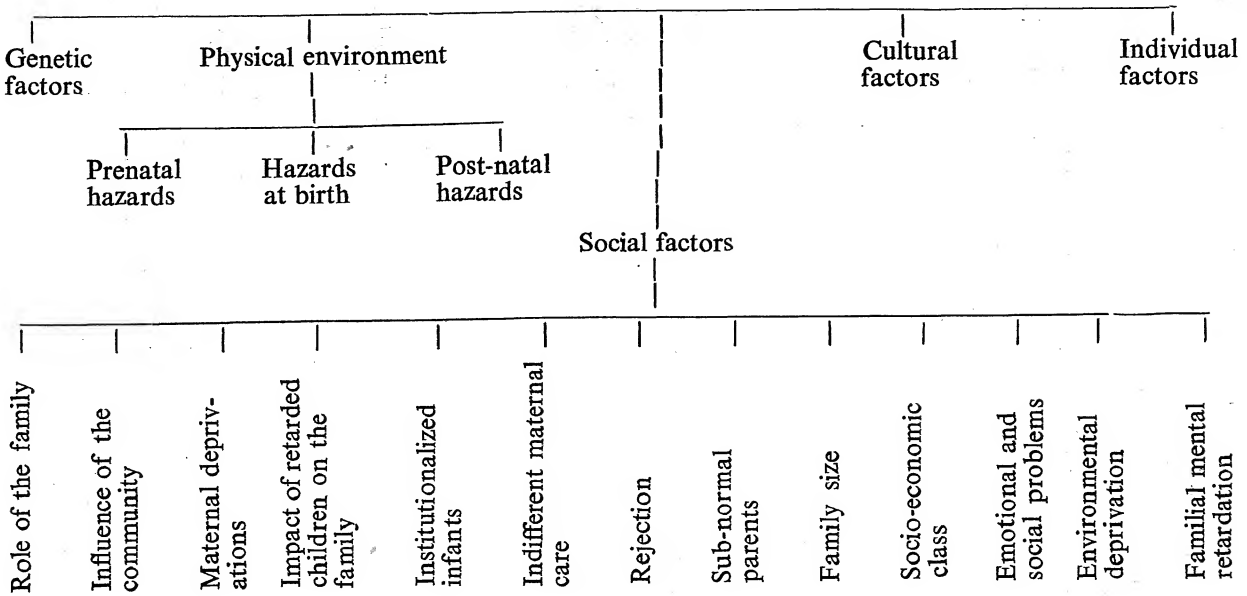
A sizeable proportion of mentally retarded children never had the slightest chance of developing properly. They were destined to be handicapped from the moment of conception, when the particular sperm and the ovum united to determine their genetic endowment. Some writers seem more than willing to attribute the genetic factors for almost all forms of mental retardation while other theorists are convinced that environment is the major if not the sole cause.

Genetic factors deserve considerable emphasis in any serious discussion of mental retardation. The undeniable causal role of genetic factors in several types of mental retardation has recently been demonstrated. "Within the past few years, for example, methods have been perfected which allow the geneticist accurately to see and to count the number of chromosomes in a human cell".[6] As a direct result, it has been shown that a number of disorders resulting in mental retardation are caused by errors in cell division which leave the fertilized egg with either too many or too few chromosomes.

During the past decade, giant steps have been taken in our understanding of the ways in which the genes direct and control

CHART 1

CAUSAL DIAGNOSIS OF MENTAL RETARDATION



many of the processes of human growth and development. To summarise very simply the process of genetic control, we can make the following points:

(i) Each of the thousands of genes distributed unevenly among the forty-six chromosomes is responsible for the production of one of the thousands of enzymes.

(ii) Each enzyme is responsible for the rate at which one of the hundreds of different chemical processes takes place within the cells.

(iii) The cell is the basic unit of life itself because it is within the cells that all the life processes occur.

Unitary elements within the cells which exert control over inherited characteristics are known as genes. There must be many thousands of these particles in every human cell, distributed unevenly among the twenty-three pairs of chromosomes.

Several of the approaches to the study of genetics have readily yielded circumstantial evidence that intelligence in human beings is at least strongly affected by genetic inheritance. Generally all genetically determined disorders are metabolic.

It does happen occasionally, however, that the presence or absence of a single chromosome, or a defect in a single gene or gene pair makes it virtually impossible for the affected individual to develop normally.

Physical Environment as a Factor

(i) *Prenatal hazards*: There are quite a few of them.

(*a*) Background of the mother: The possibility exists that factors operating long before the pregnancy, even in the early childhood of the prospective mother, may affect her productive efficiency.

Baird and Scott[7] found a significant positive relationship between the social class of the mother and not only her height but the adequacy of her pelvic shape and size, all of which were determined during the growing years. They also found a relationship between the intelligence of the mother and the number of her siblings, which was marked in the lower social classes but insignificant in upper class.

(*b*) Maternal nutrition during pregnancy: Physical abnormalities and ill health in infants whose mothers had poor diets during pregnancy, is found in most cases.

(*c*) Acute maternal infections: *Syphilis*—This disease in pregnant women used to be a major cause of a variety of neuropathological changes in their offspring including mental retardation.

Rubella (German Measles) –This disease has replaced syphilis as the major cause of congenital malformation and mental retardation due to maternal infection. The children of affected mothers may present a number of abnormalities including congenital disease, mental retardation, cataracts, deafness, microcephaly and microphthalmia.

The role of other maternal infections during pregnancy—such as influenza, cold viruses, pneumonia, and urinary tract infections—in the etiology of mental retardation are at present under extensive investigation.

(*d*) Complications of pregnancy: Toxemia of pregnancy and uncontrolled maternal diabetes present hazards to the foetus and may sometimes result in mental retardation. Maternal malnutrition during pregnancy often results in prematurity, vaginal haemorrhage; placentaprevia and premature separation of the placenta may be damaging to the foetal brain by causing anoxia.

(*e*) Maternal age: The evidence indicates that older mothers run an increased risk of producing a mentally retarded child and that the risk increases still further when the first child is born in the life of the mother.

(*f*) Parity: Parity refers to the birth order of the child, or, more precisely, to the number of the mother's pregnancies. There is an increased risk of maldevelopment after the third or fourth pregnancy. Several data indicate that a correspondence exists between parity and deficiencies of central nervous system.

(ii) *Hazards at birth*: This can be classified as follows:

(*a*) Prematurity: Many studies point to prematurity as a major cause of disorders of the central nervous system that are often associated with mental retardation.

Prematurity may result in intellectual deficits, sensory and motor handicaps, convulsive disorders and learning and emotional difficulties.

Prematurity is more prevalent in low socio-economic segments of the population. Its causes are many and include inadequate prenatal care, with resulting obstetrical complications, such as toxemia and pretoxemic states; multiple births and illegitimate pregnancy, poor maternal nutritional status, smoking habits of the mother and urinary infections.

(*b*) Birth injury: This broad term covers all types of brain damage resulting from complications of labour or delivery. Some are due to mechanical trauma, others are due to anoxia, but most cases result from an interplay between these two factors.

(iii) *Post-natal hazards*: Advances in the antibiotic therapy that permit a higher survival rate of children with infections of the central nervous system have as a corollary a high frequency of neurological sequelae in the survivors. The extent of the damage varies from mild learning or behavioural disorders to severe dementia and depends on several factors, such as the severity of the infection, the nature of the micro organism and the age of the child.

Social Factors

Although the tiny foetus seems to have been protected and remote from the society in which he will be born, his mother is by no means impervious to her social surroundings and therefore her baby cannot be impervious either. Social factors can influence the development of the foetus in many indirect ways. They may affect the nutrition of the mother, the medical care she receives during pregnancy, her general state of health, the amount of rest she obtains, and the degree to which family planning is achieved. All these factors are related to the incidence of complications during pregnancy or prematurity and of brain damage both before and during birth.

The overwhelming majority of the mentally retarded come from the lowest socio-economic group.[8] These are the indigent, dependent, helpless and hopeless and often illiterate members of racial minorities, inhabitants of backward rural communities and urban slums. Exact statistics are not available, but the estimate of

the frequency of the mental retardation in this segment of the population range between 10 and 30 per cent, contrasted with about 3 per cent in the total population. Many factors contribute to this sad picture.

(i) *The role of the family:* The role of the mother and other family members in the personality development of a young child is crucial. Usually the early closeness between the mother and the child is promoted by the mother's feeling of pride and acceptance and is continually reinformed by the child's predictable response, such as smiling, cooling, cuddling and playfulness. Delay in such responses and the knowledge of the child's mental retardation often induce parental inner turmoil, grief, a sense of disappointment, shattered hopes and sometimes feelings of guilt and failure. These feelings are unresolved, make it difficult for many parents to accept the child, to be proud of him and to give him affection and recognition.

Ignorance of the fact that the child is mentally retarded is equally hazardous.

(ii) *The influence of the community*: The community may affect the personality development of the retarded child directly or indirectly. As the child grows older and his social world widens, he comes to depend more on his peers for emotional support and stimulation. The retarded child, because of his inability to compete, is frequently excluded from neighbourhood groups, leading to further frustration and feelings of inadequacy.

(iii) *Maternal deprivation*: The retarded child needs more than usual amount of mothering, affection and stimulation. Denial of these, results in an often irretrievable loss of whatever inner resources the child possesses. This matter is of particular importance in the problem of early institutionalization.

(iv) *The impact of retarded children on the family*: Most of the studies[9] on families with mentally retarded children indicate that the period immediately following the diagnosis is extremely crucial and may have a deciding influence on the parents handling of the child in future. The ultimate impact of the retarded child on the family depends on several factors, such as the degree of the retardation, personality development and the life adjustment of each parent preceding the arrival of the retarded child, the degree of their professional and social success, the adequacy of the

marital adjustment, other children in the family and their intellectual progress, and the parental socio-economic status. It has been well suggested that parents with a positive self-image are usually able to absorb the retarded child without upsetting the family balance or jeopardizing the well being of other family members.

If, however, the parents are emotionally immature and beset by neurotic conflicts, the arrival of a defective child may precipitate a crisis that sometimes leads to family breakdown.

(v) *Institutionalised infants*: A great deal of the evidence underlying the conviction that the disturbance of the maternal relationship is fraught with danger, comes from studies of babies who for one reason or another have been institutionalized. Most of these babies have been given up for adoption because they were illegitimate. By and large, institutional care is improving rapidly, but in many hospitals and orphanage nurseries babies receive the minimum of stimulation, diversion, physical contact, physical freedom and interpersonal contact. A baby might well spend his entire day, except for his bath, in an antiseptic cubicle without hearing, seeing, feeling or smelling any moving, living, changing, stimulus except for the briefest and most perfunctory intervals. If he rolled over, babbled or sat up, there was no one to take notice or encourage him to do it again. He might, in fact, stay so long in the same position in his crib that the mattress would sink in the centre effectively preventing him from making any further movements.

Studies of institutionalized infants therefore have tended to be studies not only of babies deprived of maternal affection and attention but of babies deprived of the normal activity of the home[10]. Investigators have found dramatic retardation in infants who have been institutionalized under rather impersonal conditions.

(vi) *Indifferent maternal care*: Institutions are not, of course, the only settings in which babies may receive impersonal care. An unstable or indifferent mother, a mother who is overburdened with the care of many children, or a mother who is antagonistic towards her baby or her role as mother may provide minimum physical care unembellished by personal warmth or by an

environment in which there is variety, stimulation, and responsiveness. These children become by no means typical of children with retarded mental ability.

(vii) *Rejection*: The unwanted or disliked child in the family setting may be rejected in numerous ways. One form of rejection is, of course, indifference and impersonal care, such as that described above. Other expressions of rejection tend to be more active and to be reflected in hostility in the emotional atmosphere and in mishandling rather than in ignoring the child. Apparently, these situations tend to produce symptoms which are expressed primarily by tension and conflict and only secondarily by intellectual deficit. Tensions and conflict do not ordinarily permit maximal intellectual growth, and many rejected children who would otherwise have achieved normal intelligence may function within the mildly subnormal range. Severe rejection may seriously damage their capacities for planning, striving, understanding and control.[11]

(viii) *Subnormal parents*: No matter what the genetic component is which helps to determine intelligence, the child born to parents of subnormal mental ability is likely to receive ill advice and inconsistent care, so that on the basis of environmental effects alone his intellectual growth may easily suffer. A subnormal mother does not possess adequate knowledge about famliy planning or child care; she is probably annoyed by or at best indifferent to the child's presence and is less deeply concerned with his needs than with her own. Since there are often many children in the family, the baby receives little affection or attention. Finally, the home is likely to be devoid of toys or books to occupy and stimulate the baby's growth and powers of discrimination.[12]

Added to the personal ineptitudes of the mentally subnormal mother are the economic and social problems faced by a couple in which the father is like-wise mentally subnormal or emotionally disturbed. In this group hereditary and environmental factors are closely interwoven. Children in this group tend to be only mildly handicapped.

(ix) *Family size*: Increasing attention has been paid to the intricate relationships between family size and intelligence. All kinds of resources—financial, emotional and spatial—are divided into smaller amounts in large families than would be the case if the same parents had fewer children, especially in the lower

socio-economic classes. Although the flexibility of a large family may be at times be an asset, an advantage, too often the increased size of the family means that each child receives a smaller amount of attention from the parents.

(x) *Socio-economic class*: It has been recognised that IQ* of children tends to vary with the socio-economic status of their families[13]. Numerous investigators have found that children's scores on conventional intelligence tests substantially correlated with such socio-economic factors as the father's occupation, the parents education and family income.

(xi) *Social class and mental retardation*: The effect of social class status is directly related to the etiology of the mildly retarded child. It has been repeatedly noted that mildly retarded children tend to come from lower class backgrounds, while severely retarded children come from homes which more nearly resemble a cross-section of the general population.

(xii) *Emotional and social problems*: The majority of disadvantaged families are upwardly mobile, have sound ambitions for their children and have not given up the struggle to help themselves. Family cohesion is often missing, the children are often illegitimate and reared by a variety of caretakers in addition to the mother, who is frequently working. In such an environment, the dependency needs of the growing infant, toddler, and young child may not be met and he is forced to fend for himself long before he is ready. The fatalistic, hopeless attitudes of the slum environment can stifle initiative and motivation. As a result of living in a world that seems hostile, without encouragement and praise, the child's self-concept, including his body image, may be faulty.

(xiii) *Environmental deprivation*: It is particularly in the institutional setting for infants and young children that the greatest hazards exist for environmental deprivation. Hospital nurseries, too, must provide a stimulating environment for babies.

(xiv) *Familial mental retardation*: It was the usual practice in the past to begin the classification of the mentally retarded with the large category of familial retardation, also known as garden variety, physiological retardation or 'poor protoplasm'.

*IQ : Intelligence Quotient.

There is fairly wide agreement as to some characteristics of children in this category. It's members comprise about 75 per cent of all the mentally retarded in this country and usually come from the lowest socio-economic group. In addition to being mentally retarded, they are the chief contributors to the ranks of juvenile delinquents, the jobless and the mentally ill. They have no neurological signs, neuropathological abnormalities, chromosomal or biochemical characteristics to distinguish them from the rest of the population. Finally, in border-line to mild retardation there is usually a consistency in IQ among members of the same family.

Cultural Factors

Studies have shown rather clearly that children (a) with high IQs from lower socio-economic groups did not continue to function at those high levels and did not make an effort to go on to college and (b) with high IQs from middle-class and upper class socio-economic groups did go on to college and into professional fields. We can conclude from this that the level to which an individual will aspire is dependent largely, upon the degree of importance he places on the goals and motivations and rewards that are being associated with a particular behaviour under consideration.

Within any large city we can find devastating effects of cultural deprivation or perhaps subcultural differences. On any test that is standardised on the general population, such as the Stanford-Binet, this would, of course, show up as a higher incidence of labelled mental retardation.

Migration and immigration can serve as good examples here. When suddenly new demands are made upon groups of people, coming from a more disadvantaged limited background and moving into a culturally more advanced milieu, they will first show a high incidence of labelled deficiency or retardation but this will disappear as the group becomes assimilated.

Individual Factors

An individual is a complex personality, with many skills and weaknesses, which vary from person to person. It is well recognised that two individuals, having the same IQ, may have arrived at this score by several different combinations of passes and failures

on specific items within the test. For example, a two-year-old child, who is quite proficient in his motor ability and rather deficient in his language development may, at four years, be rather proficient in his language development and relatively deficient in his motor development.

An individual does not remain static. He either progresses or falls behind as time passes, depending upon the attitudes and actions of society, the home and eventually, his own initiative.

Factors of Mental Retardation in Researches

The first important investigation in which the problem of mental retardation was viewed from both sociological and psychiatric angle and was reported was that of the French Physician J.M.G. Itard,[14] who published in 1801 an account of his attempts to educate the wild boy of Aveyron. A youth of about 11 or 12 had been found living in a wild state in the woods near Aveyron. Filled with the spirit of scientific enquiry, Itard attempted to socialise him by kindness and human association and to train him 'through the senses'.

But unfortunately, Itard was only partially successful. The account of his work remains one of the great contributions to pedagogy.

If we review the immediate background about this problem in England and in the United States, we find, in the former at least, the development of the Welfare State in the post-war years sensitized public awareness of the deprived members of the population and this led to particular concern for the conditions of those in mental and mental deficiency hospitals.

In England the best known study of mentally deficient was carried out by Goddard (1916),[15] who described in detail the two families stemming from the same father, Martin Kallikak. This man joined one of the many Military Companies that were formed at the time of the American Revolution and while on service formed an association with a feeble-maiden girl whom he had met in a tavern. He had an illegitimate son by this girl, gave the child his father's name in full.

Martin Kallikak provided a control group by marrying later a respectable girl of a good family by whom he had further children. Their descendants had a superior social and economic status, married into the best family in their state, produced

respectable citizens, men and women prominent in every phase of social life.

The study reveals that the genetic factors is of extensive importance for the causation of mental retardation. While going through the study of Goddard the first question arises that the basic data are of unknown validity, and that genetic and environmental factors cannot be assessed separately. Thus, little is really known about the girl who gave birth to Kallikak's illegitimate sons; if she was feeble-minded it would have been important to know something about the cause of her condition but in retrospective research this was clearly impossible. Further, the state of squalor in which she lived, together with her own mental subnormality, regardless of genetics, would seem likely to have had a profoundly adverse effect upon her son, and as is well known, a vicious circle is often initiated in such circumstances.

The families of 250 idiots and imbeciles 'on the books' of the London County Council were interviewed and records describing the defectives and the family situation were scrutinised. The survey obtained information about: (i) the prevalence of mental and physical disabilities of the defectives; (ii) the conditions of life of the physical disabilities of the defectives; (iii) the conditions of life of the families and the problems they had in bringing up mentally retarded children; and (iv) the extent and adequacy of the social and medical services, the parent's opinion about them, and their role in determining whether the defectives went into institutional care or remained at home.

The two sets of families presented very different patterns. Those with the children living at home were on the average worse off economically, more overcrowded, with proper housing and fewer social contacts than the families with a child in an institution. As far as could be determined, it was the presence of the defective in the family which accounted for these differences. Two-thirds of the families with the defective living at home had at least three severe family problems as compared with 45 per cent of those with a similar child in an institution. The families who kept their mentally subnormal children at homes suffered more for doing so.

The major factors leading to institutional placement (apart from problems of management which accounted for half the placements) were family problems such as broken homes, adverse

housing, adverse effects of sibs, social or medical grounds and mother's ill health.

None of the problems brought to light in the social survey of London families was of course new. But the number, the severity and the range of problems had not been studied systematically before and the purpose of the research was to make good this lack of information. The enquiry pointed to the need to provide better community services for parents living in their own homes and for their families, and to delineate the range of problems that they should be concerned with.

In the United States, a similar accelerated development has taken place during the last decade. This has been reviewed by Gibson.[16] Between 1946 and 1960, according to this writer, changing social conditions brought sharply increased community expectations for improved educational and other services. This renaissance in public and professional concern reached its peak in 1962 with the Report of the President's Panel on Mental Retardation.

In Canada, J.P. Das and D.E. Orn[17] studied the "Biographical characteristics and socio-economic status of children below IQ 100." Authors examined the home environment in the child's intellectual growth.

They found that the first born had a slightly higher IQ than the later borns. IQ showed a consistent increment from the lowest to the highest SES* levels. Stable homes have higher SES than broken homes. In SES the regular class children had higher level than those from the special class.

The research conducted is no doubt very much beneficial and it helps in accumulation of different data concerning SES and mental subnormality. Only one point that strikes the mind is the IQ level chosen for the samples by the authors is very high, i.e. the authors have taken the samples whose IQ are below 100, which can be taken as a normal standard according to the criteria of mental retardation based on IQ level.

The most important research, relevant for the present work, has been done at Scotland. A study on mentally retarded children of lower social class has been undertaken in a city of Scotland which is a very important and revealing study. The review of the study conducted as said above, is given overleaf :

*SES : Socio-Economic Status.

Family conditions and mild mental subnormality in lower social classes—mental subnormality in the community—A clinical and epidemiological study by Herbert G. Birch, Stephen A. Richardson, Sir Dugald Bair, Gordon Horbin, Raymond Illstey.[18] The Williams and Wilkins Company, Baltimore (1970) city selected for study was Aberdeen, Scotland (1961), population of the city—1,87,000 approximately. Age range of the retarded children—8 to 10 years. Number of sample—104.

The study concludes that :

(i) Minimal subnormality is over-represented in families characterised by a size of five children or more, residence interwar tenements, crowded housing conditions and mothers who are engaged in semi and unskilled manual occupations prior to marriage.

(ii) Borderline subnormality is over represented in the same types of family, though not to the same extent as minimal subnormality.

(iii) When within social class V, the family characteristics of five children or more and residence in interwar tenements are analysed together, greater precision is achieved in identifying families at risk of having 8 to 10 years old minimally subnormal child than when each characteristic is examined separately.

(iv) There is an association between higher risk conditions and lower intellectual functioning among the siblings of minimally subnormal children in social class IV and V.

(v) The association between higher risk conditions and lower intellectual functioning exists in the population of all 8 to 10 years old children in social classes IV and V who are not mentally subnormal.

Social Background Factors of Mental Retardation in Indian Researches

In the field of research about mental retardation in India the picture is even dismal. A well documented bibliography of behavioural science research in India[19] could hardly get 38 studies of which only 8 being published ones—on retardation in 40 years period from 1925 to 1965.

Bestowed with the inevitable task of reviewing the research in the field of retardation in India, Das (1968)[20] had to seek recourse to the work done abroad by Indians in this area to make up a

representable review in an international publication. Das (1968) was forced to comment that "the quality or quantity of research under any of these categories is not high and very little research has been done in India."[21]

As mentioned above very few researches are conducted in India about the problem itself, hence only a few of them which are related with the present research work are reviewed here.

J.S. Gandhi and M. Cheena[22] in their record "A follow up of the mentally retarded", aimed at studying the attitudes of the mentally retarded towards what they were doing and the attitudes of parents towards their children's occupation.

The authors took 13 mentally retarded boys who left the above institution during the year 1964-68; the age range was 13 to 23 years and the range of their mental age was 5 to 12 years and IQ range was 40 to 75. The procedure of enquiry was by interview method. The earnings by the subjects were from Rs 25 to Rs 150.

The sample of the present study is very small. Thus it cannot be generalised. A larger study is required in this field.

The study could have been more useful if the authors could find correlation between CA and Earning, CA and Adjustment, MA and Output, MA and Adjustment.

The authors might have also found out the relationship between duration of stay in an institution and earning and adjustment in occupation and between acceptance of the retarded in society and adjustment in life.

Age group for consideration has been taken to be between 13 and 23 years; for normal retarded child at the lower end of the group of studies. It cannot be expected for children taking to occupation at the age of 13 years. Only in a low economic social status for some menial occupation children of such age can be found. In this respect the study is not very objective. Due to the variance in economic and social surroundings this study by the authors lack in objective analysis.

Besides these shortcomings, the follow up studies are useful in determining the level of success of efforts made in a particular direction. This study by the above two authors is also very useful because much work has not been done in this direction. In spite

of the shortcomings the study is useful because in India such studies are rare.

Another study has been done by S.G. Damle.[23] The aim of this study was to explore the background of a group of children of varying degrees of mental retardation. To this end a brief study is made of the physical and mental condition of the mothers during pregnancy and at child birth as well as their food intake during pregnancy. An attempt is also made to throw light on the post-natal care of the children, such as, their feeding, illness and accidents in infancy and childhood, their habits and behaviour problems and other aspects of their developmental history. The study further includes the child's family history, school adjustment and parental attitudes towards their problems.

For the purpose of this investigation, forty-five children (age range 6 to 18 years) whose IQs were below 78-79 males and 16 females were selected from among those referred to the Child Guidance Clinic of the Tata Institute of Social Science for behavioural problems.

He draws the conclusion that this has brought to light the fact that parents generally need more knowledge and information regarding the treatment and care of their mentally deficient children.

Important Research Works

Some of the important research works which are related with the present research are reviewed as under:

Molony Helen[24] "Parental Reactions to Mental Retardation": In his research work the author describes the three stages of parental reaction to the discovery that their child is mentally retarded. At the first stage the parents are shocked and they try to disbelieve the fact, in the second stage they partially accept and partially deny the fact and the third stage achieved only by some, is that of reintegration followed by mature adaptation.

Winterbourn, Ralph[25] "Effect On Parents, Brothers And Sisters": The author discusses the reactions of a family to mental retardation. After discovery of the fact that their child is mentally retarded the parents seem to go through the four stages of reactions. At the first stage they get a shock, in the second stage they disbelieve the fact, in the third stage they are afraid and become frustrated and finally they accept the fact. Normal children

should not be neglected and they should not be over-emotional with the retarded child.

Comparative studies

Lippman-Leopold,[26] *Attitude Toward the Handicapped: A Comparison Between Europe and the United States*: In this book the author reveals his observations of differences in attitudes towards and treatment particularly of the mentally retarded in Europe and United States.

Lippman in his investigation mainly points out that Europeans are more successful in integrating the mentally retarded or exceptional person into the fabric of society.

Flax, Norman, Peters, Edward N.[27]—"Retarded Children At Camp With Normal Children": In this investigation the author states that every year administrators of summer camps face the problem of accepting the handicapped (both physically and mentally) children along with the normal children at the Jewish Community Center Association of St. Louis, Missouri. In his recent experience the author finds that the normal children and their parents are not against accepting the retarded in their camp, because the behavioural characteristics of the retarded children fall well within the range of those exhibited by normal children.

Vurdelja-Maglajlic, Dada, Jordan, John[28]—"Attitude-Behaviours Toward Retardation of Mothers of Retarded and Non-Retarded in Four Nations": The authors studied the attitude of mothers towards retarded and non-retarded in four nations, namely Yugoslavia, Germany, Israel and Michigan (US) which differ culturally, economically and politically.

The authors conclude that in the underdeveloped nations the attitude of the mothers toward their retarded children were more positive than the attitude of the mothers of the non-retarded children.

Fotheringham, John B, Skelton, Mora, Hoddinott, Bernard A[29] "The Retarded Child And His Family: The Effects of Home and Institution": In this research work the authors present two groups of retarded children and their families. It is a comparative study in which one group of children was placed in a large provincial institution and the other group remained with their families. Both groups were evaluated—firstly prior to admission and secondly one year after the admission. The authors found that the children

admitted in the institution exhibited more behaviour problems, were more unsocial than the non-institutionalised children and there was no significant improvement of those children at the institution.

Bernard, Allen William[30]—"A Comparative Study of Marital Integration and Sibling Role, Tension Differences beween Families who have a Severely Mentally Retarded Child and Families of Non-Handicapped Children" : The author in his research work compares the disparity of differences of marital integration, sibling role tension, neighbourliness and religious participation between families having a severely mentally retarded child and the family having normal children. The research reveals that in the case of the families having a severely retarded child the marital integration is not adversely affected. Such families do not possess prolonged negative feelings affecting the marriage, tension level of siblings, neighbourliness and religious participation.

Major Terms Defined

The terms related to mental retardation which have been used frequently in the present study are :

Intelligence Quotient (IQ)

Mental Age (MA) is a notion introduced by Alfred Binet (Binet and Simon[31]) for measuring the child's intellectual development. A specific mental age expresses the average intellectual attainment of children of that Chronological Age (CA). This concept is used routinely in intelligence tests in which test items are arranged by age levels. Items are tested on representative groups of children at successive age levels. When such a test is administered, the child is given all the items in the range of his abilities, including the highest level at which he can pass all the items (Basal Age) and the lowest level at which he fails all of them (Ceiling Age). MA score is obtained by adding to the Basal Age level credit for each item passed at any age level above it.

Terman[32] introduced a further refinement, the *intelligence quotient* or IQ. This measure is obtained by dividing an individual's mental age by his chronological age and multiplying by 100.

Intelligence

The observation that individuals differ in their intellectual abilities surely antedates recorded history. The earliest writings contain thoughtful references to difference in mental functioning. More than 2,000 years ago, for example, in a discussion which has a peculiar modern ring, Plato suggested in *The Republic* that individual variations in intelligence must be a basic determinant of the social and political order in any workable society. Even though man has pondered the nature of intelligence and its importance in human affairs since the beginning of civilization, no single definition of intelligence has ever satisfied all or even a majority of those who have been concerned with the concept.

Even in the midst of popular concern with intelligence and of vast expenditures of private and public funds for studies connected with education and development, the confusion about the nature of intelligence still exists, indeed, the concept is almost obscure now as it was many years ago. Paradoxically, greater and greater efforts are being made to develop information about intelligence, although few agree on a definition of what they consider intelligence to be.

A great many diverse ideas about the basic nature of intelligence have been recorded in the past half-century. Theorists have tended to emphasise: (i) the capacity to learn, (ii) the totality of the knowledge which has been acquired, and (iii) the ability to adjust or to adapt to the total environment, particularly to new situations.

Binet and Simon defined intelligence as "the sum total of all those thought processes which consist in mental adaptation".

Comprehensive definition

Representatives of those who have combined and extended the types of definitions previously discussed are David Wechsler and George D. Stoddard.[33] Wechsler has defined intelligence as "the aggregate or global capacity of the individual to act purposefully, think rationally and to deal effectively with his environment."

Intelligence is seen as 'global' because it characterises behaviour as a whole, and it is 'aggregate' because it is composed of elements or abilities which, though entirely independent, are qualitatively differentiable.

Mental Subnormality, Mental Deficiency, Amentia, Oligophrenia and Mental Retardation

All these terms primarily indicate defective development of intelligence. Hence all the above terms referred time to time in the research work have almost the same meaning.

Social Competence and Mental Retardation

The concept of social competence is so value laden and its definition so vague that it is very difficult to define it. Windle (1962)[34] has pointed out that the social competence definition of mental retardation is applicable to institutionalised populations whereas quite different definitional criteria must be employed with non-institutionalised populations. The only clear and acceptable operational definition of social competence would appear to be related to whether the individual has managed to function outside an institutional setting. It is impossible for anyone who is truly retarded to meet the complex demands of our society.

Delinquency and Mental Retardation

It is said that the incidence of crime among the retarded is higher than among the non-retarded. Review of some of the researches concerning mental retardation and crime reveals that severely subnormal children are incapable of committing crime. Those who are comparatively less backward, are more prone to crime. The former are more easily arrested owing to their foolishness. It was found that IQ of the majority of delinquents ranges between 55 and 85. Their physical constitution is of muscular and athletic type. They think with their hands rather than with their heads. They come from large families where there is overcrowding and little stimulus to education. Severe deprivations affect their intellectual and emotional development adversely. Mostly their parents are also dull and are subject to illness and unemployment. If the parents are not intelligent the child may be rejected because of his dullness. Then the unwanted child commits crime to compensate for his deficiency. And these retarded children on attaining puberty may commit minor sex offences owing to their lack of control over the sex crime.

Mental Retardation among Children and Adults

According to Burt[35] children are defectives if they possess an IQ below 70 and adults if there IQ is below 50. The cause of distinction lies in the fact that in cases of children and adults two different social criteria are used to diagnose mental deficiency. We have seen that the need of 'care', 'supervision' or 'control' is a criterion for retardation in adults. This criterion cannot be applied to children; if we do so, then all children become retarded. The criterion for deficiency in children is a socio-educational one as distinct from that of adults which is socio-economic.

Mental Retardation—A Relative Concept

Mental retardation is always understood by referring to the individual's innate ability to meet the social demands made upon them. The social demands on individuals, however, vary considerably in different strata of society. It is generally found that a child with an IQ of 70, is relatively a normal person in a family of unskilled manual workers. If he does not suffer from an additional deficiency in his motor aptitude, other things being fairly satisfactory, chances are he would not face much problem in his life. A child with the same IQ in the family of a professional is a source of untold worries and vexations since he is relatively so little educable in the scholastic sense of the term.

There is also a difference in the social demand on the two sexes. There are some difference in the psychological meaning of mental deficiency in cases of men and women. We have found that a young man of 17 years with IQ of 75 is a "grave problem" in a family of professionals while a young woman with IQ of 73 in a somewhat similar family is considered if at all, a not so serious matter.

Focus of the Present Study

The evolution of the concept of mental retardation has been explained. The causal factors, associated with mental retardation as deduced from researches, have been summarised. Only those studies have been reviewed which study mainly the social and family background of the mentally retarded children.

The social factors of mental retardation have been emphasised particularly by the study of H.G. Berch *et al.*, of Scotland and

S.G. Damle of India. These findings relate to the problem of the present study.

The main aim of the present work is to find out the family conditions of the mentally retarded children. The family background constitute has been reduced to characteristics of the parent's caste and community, income and occupation, sibling order and other relevant factors of family history of the mentally retarded children.

The aim of the research is to find out the significant association of these background factors with the incidence of mental retardation in families under study.

Any causal hypothesis has not been tested but the study had to focus upon the following hypotheses:

Prevalence of mental retardation is related with the socio-economic conditions of the families; the nature of the marital relation is not healthy in the families of retarded children, quarrelsome and tragic joint families help in bringing about mental retardation; frequency of premature death is higher in this group; these children are mostly unwanted and rejected by their parents. For operational purposes of the study, the family conditions of normal children are compared with the family conditions of the mentally retarded children (these groups grouped as, mentally retarded and normal children are taken as comparison groups), on the following matching attributes, details of which are described in the chapter on Research Design—(*i*) age of parents, (*ii*) education of parents, (*iii*) income of parents, and (*iv*) age of children.

For the purpose of this study only those cases of mentally retarded children have been taken up which were reported by the Child Guidance Clinic, the project for Mentally Retarded Children and G.C.M. School for mentally retarded children (field of study from where samples collected—discussed in the chapter on Research Design.) The institutions had already carried out IQ tests and the children were declared mentally retarded on the basis of their performance level.

Those children were taken into account to be normal children, whose parents did not visualise any abnormality or retardation in their children and were specified to be normal children.

The necessary findings of the two groups have been compared and the differences and similarities between them analysed.

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2

Research Design

The Prevalence of Mental Retardation

No definite answers can be expected to statistical questions concerning the worldwide prevalence of intellectual retardation. Mental retardation is not a disease entity like measles or pneumonia. In a large sense, a person does not have it except in the context of the community in which he lives. A child with an IQ of 95 may be more greatly handicapped in the highly complex New York city than one with an IQ of 65 in a rural settlement in India. A Committee of the World Health Organization (WHO) of the United Nations reported, for example, that the proportions of children regarded as educationally subnormal in different countries vary greatly according to the criteria employed. Dutch estimates based on eight large cities give a mean rate of 2.6%; French estimates range from 1.5% to 8.6% depending on age; English educational practice aims to make provision for 1% of school children in special schools, while further 8% or 9% are considered to require special educational provision within the ordinary school system.[1]

In United States, Wallin (1958)[2], lists sixty studies conducted between 1894 and 1958 in which estimates of the mentally retarded range from .05% to 13% of the population.

Extent of the Problem in India

There has hardly been any systematic sociological study of the problem of mentally retardates in India. But it is estimated that 3% of total population are mentally retarded. This means that the total number of the retardates in India is approximately 15 million. Wallin (1958) states: "There are about 1.5 to 1.8 million mentally

retarded children of the age group of 6 to 14 years. Even in UP there are 2.5 million mentally retardates".

There are only 51 institutions in India helping 2,000 mental retardates. In UP there are only 5 institutions helping about 200 mentally retarded children. This shows the enormous gap between the needs and the services actually available.

Therefore Indian society has an obligation to help in the rehabilitation of the mentally retarded children. In the developed countries such as in America, England, Canada, France, governments and the intellectuals have given much attention to this problem. Unfortunately, in India, the problem of mental retardation has not received as much attention as the problem of other physically handicapped. This is due to a variety of reasons including its magnitude and complexity. Whatever the causes, the failure of mentally retarded individuals to adjust successfully to social and economic conditions of our society constitutes a severe and growing handicap for the individual, for his family and for the society. Moreover, as our competitive society becomes more complex and fast moving, the demands for intellectual capacity and for adaptability increases. Thus in an age of automation, individuals with minimal skills and abilities become doubly handicapped. Not only do they face an increasingly competitive society, but hampered as they are, they must keep pace with people of increasingly higher capacities. Thus they become more easily submerged by the vicissitudes which others can surmount.

Statement of the Problem

Problem of mentally retarded children has become very acute with increasing complexity of our industrial urban society.

Recent research has pointed out increasingly to educational deprivation and other social, cultural and economic factors as associated causes of mental retardation. In the present research it has been emphasised that an adequate social and cultural environment is essential for normal intellectual development of a child.

Theoretical Importance

This problem of mental retardation involves a big social cost. Problems of such children are not only the problem of their own,

but of their parents, family, peer groups, institutions and ultimately for the whole of the society.

Although in India researches have been conducted on other aspects of the problem, for example, its medical aspect, psychological aspect and psychiatric aspects, almost no research has yet been conducted in India in social background.

Applied Value of the Problem

"The attitude of the State towards the problem is not very encouraging, an evaluation of the professional services for the retarded makes an ever grimmer picture."[3]

The review of research literature related to the problem, presented in the foregoing pages, indicates that no comparative studies were conducted in India on family conditions of mentally retarded and normal children. The present study aims to find out the concomitant relationship of two variables; the social conditions and mental retardation.

It has been well established that adequate social and cultural environment is an essential prerequisite for normal intellectual development of a child. Poor socio-economic environment and emotional deprivation can therefore lead to apparent mental deficit in such cases as may be attributable to delayed maturation. Guertin[4] who studied 25 patients from a state school who had shown marked increase in their IQ and were classified as having dull, normal or higher intelligence, established that mental development of these patients was slow; the mean increase in their IQ was 23.7 points. The increase in IQ occurred after the age of 16 years and that they came from poor home environments, providing thereby that the apparent mental deficit shown by these patients stemmed from environment under stimulation. Raja Lakshmi[5] studied children in an orphanage in South India and home reared children in a village near the orphanage and concluded that the mental backwardness in these children resulted from the environment in which they lived.

Home influence

Parental attitude towards the child and towards each other give early direction to later behaviour; love, affection, and security in the house have a wholesome effect upon the child. Rejection,

lack of affection and unpredicable discipline are extremely harmful. Absence of one parent or both may have an effect so profound that normal development of intelligence may appear to be lower. The child's home life is by and large responsible for socially unacceptable behaviour towards others. In his early years a child who is deprived of normal experiences associated with home life may show extreme retardation in many phases of his growth. Every child seems to need the attention and love of his mother from the very first days of his life. He needs to explore the world from her arms. Later on he needs his mother to keep him patiently and lovingly through new and trying experiences. He needs her affection and protection up to the time he enters special school and even beyond.

Many studies indicate that children from home with higher economic levels show better overall development in growth and behaviour. A home which sets standards of social emotional behaviour too high for the child to meet, may contribute to his personality. Home standards too strict may harm the child to such an extent that he becomes emotionally or socially maladjusted.

The Status of Interest in the Field of Mental Retardation

Public and professional interest in the etiology of mental retardation and in the problems faced by retarded children and their families has been at best meagre and sporadic. This apathy has persisted despite the high incidence of mental subnormality throughout the world, a problem which no society can avoid. Yet until recent years training schools and other public facilities have suffered from a general lack of attention, a lack of financial support and a lack of trained personnel. Probably no other public health problem of such enormity has been so blatantly neglected.

Sources of Apathy

There are reasons behind the apathy which has hampered research and treatment of the handicapped persons. Some of the reasons for apathetic attitude are as follows:

(i) *Cultural taboos*: Many families have felt deep shame at the presence of a retarded child. They have tried to hide him,

deny his handicap, and place him in an institution without further family contact. Although these taboos are fast disappearing, their remnants remain surprisingly strong.

(ii) *The notion of incurability*: It was earlier believed that retardation was incurable. On the other hand it was said that if a child developed into a reasonably adequate adult, this proved that he had never been mentally retarded. This attitude which is fortunately less prevalent today, had lead to widespread apathy and to half-hearted attempts at treatment.

(iii) *Understaffed institutions*: Institutions have customarily been understaffed, with their professional personnel consisting mainly of overworked physicians as directors and devoted but untrained caretakers in day-to-day contact with the patients. In many communities, the psychologist who tests the child prior to admission, is not directly connected with any institution and many have no further contact with the child after the tests have been completed.

Growing Interest in the Field

After a long period of gross neglect, mental retardation, it seems, has at last come of age in the list of human ills. We find evidence of these developing concerns, which we can name here:

(a) *Financial support for research*: Our States and Central government provide Grant funds for research in many areas of the behavioural, medical and physical sciences. In the field of mental retardation India is getting tremendous help from the Department of Health, Education and Welfare, United States of America.

(b) *Improved medical care*: General improvement in public hospitals has aided the overall situation. By and large, the new residential centres emphasize treatment and rehabilitation rather than mere custodial care.

(c) *Advances in scientific fields*: Recent advances in many of the specialized medical and behavioural sciences which have some bearing in the field of mental retardation have influenced professional and public interest in the problems in the field.

(d) *Advances in treatment and education*: More recent attempts are helping the child with intellectual limitations to achieve emotional maturity through psychotherapy, and have begun to be somewhat more hopeful.

Hypotheses

As regards the comparative study of family conditions of mentally retarded and normal children, the following hypotheses are presented:

(i) Prevalence of mental retardation is inversely related with the socio-economic class, i.e. more cases of retarded children are found in lower social classes.

(ii) Marital status of the parents is not healthy in the families of the mentally retarded children.

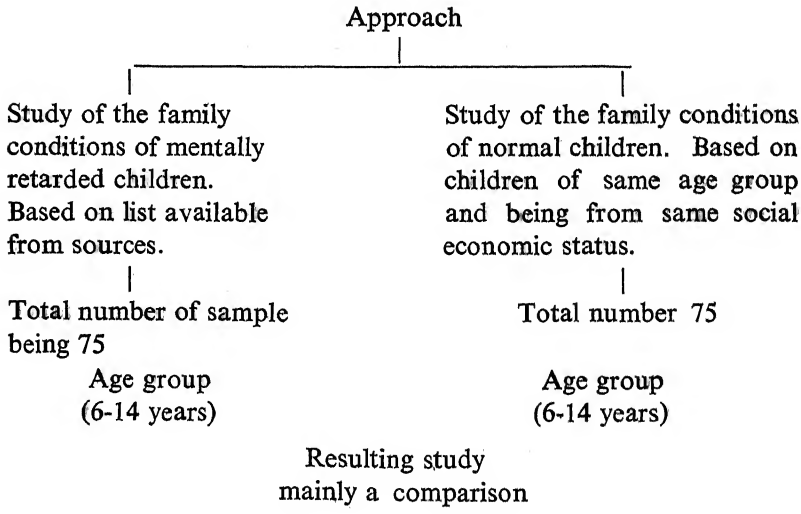
(iii) Delinquency and mental retardation are frequent.

(iv) Most of the mentally retarded children are unwanted and rejected by the parents.

(v) Quarrelsome and unhappy joint family situations help in bringing about mental retardation in children.

(vi) Premature death of one or both the parents are found in most cases of mentally retarded children in comparison to normal children.

Approach of the Study: This can be schematically represented as shown below.



Survey

By Interview Schedules approaching every family concerned.

Nature of Study

It is a comparative study of involvement of family of mentally retarded children in the creation of conditions for mental retardation as a social problem with that of family of normal children.

Universe

The present study has the field within Varanasi. Varanasi 25.18 degrees N. Lat. and 83.1 degrees E. Long. also popular as Kashi, is a city of great antiquity with holy traditions of religious sanctity, learning art and culture, and has been able to maintain its ancient associations and distinction. It has been undoubtedly one of the first Aryan settlements in the middle Ganga valley probably first occupied by pre-Aryan settlers who worshipped Shiva as their patron deity. With a population of 28.53 lakhs Varanasi is the fifth most populous district of Uttar Pradesh.

For the present study the following centres have been selected for collection of samples of retarded children from Varanasi district.

S.No.	Name of the institutions with address	Number of samples
1	GCM School for Mentally Retarded Children, Kashi Vidyapith Road, Varanasi	35
2	Research Project on Education, Treatment and Rehabilitation of mentally retardates, School of Social Work, Kashi Vidyapith, Varanasi	30
3	Child Guidance Clinic, Maldahiya, Varanasi	10

GCM School

This school was started by Shri Raja Ram Shastri, Member of Parliament, the then Vice-Chancellor of Kashi Vidyapith in the building donated by Smt. Kashmiro Devi in the memory of her husband, Late Sri Gyan Chand Murabbewale.

The school gives special education and training to mentally retarded children. It also makes arrangements for proper medical, psychological and psychiatric examinations of such children and helps them in utilizing the existing treatment services available in the community. The school also offers consulting services to all the applicants whether they get admission or not.

The sole guideline is to give social help for developing their IQ and developing a capability of some vocational aptitude so that such children may be rehabilitated.

Research Project

The particular research project was designed to devise ways and means of education, treatment and rehabilitation of mentally retardates. The aim of the project was to develop and evaluate strengthened day-care and extra institutional services. Great emphasis was laid on parental responsibility and participation rather than isolation of the child in a residential institution in this research project.

Child Guidance Clinic

This is an institution where mentally retarded children are brought for testing their Intelligence Quotient and for proper guidance. Though it is smaller in magnitude and activity yet they have a very efficient office and good staff.

Collection of Samples

Samples have been collected for the present study from the above three sources. For these samples the institutions concerned gave names and addresses of mentally retarded children about whom detailed discussions and process of study will be revealed in the empirical portion of the study.

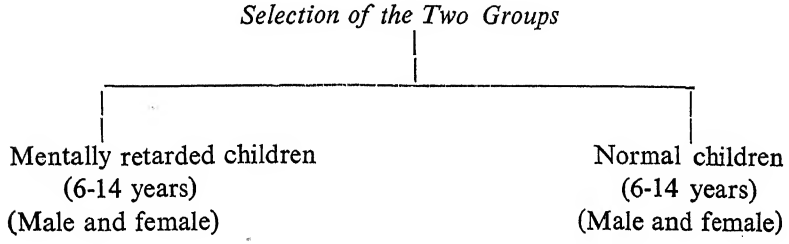
But these sources have been used only for the purposes of obtaining the addresses of mentally retarded children and for knowing their records. The field of the present book has been mainly the family conditions of the mentally retarded children and the family conditions of normal children.

Sample Spectrum

The sampling in this study is being done on the basis of quota sampling.

Purposive quota sampling : "The basic assumption behind the purposive sampling is that with good judgement and an appropriate strategy, one can hand-pick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one's needs."[6]

"The basic goal of quota sampling is the selection of a sample that is a replica of the population to which one wants to generalize, hence the notion that it 'represents' that population."[7] Thus the project of the study is:



The family conditions of the group of normal children has been used as comparison with the family conditions of the group of mentally retarded children. The list of mentally retarded children was collected from the above-mentioned sources by quota sampling. Only those children who were already admitted in the above-mentioned institutions and were tested as retarded, were taken as samples of one group. Those children who were not admitted in any special handicapped school and whose parents did not visualise any abnormality in behaviour of their children, were taken as the sample-group of normal children. The total number of the samples in either case is 75.

Socio-economic Status of the Respondents

The Kuppuswamy[8] Scale has been used for measuring the socio-economic status of the parents or guardians of the retarded children. The class position is determined through the status score values which vary as follows: 29-26 Elite Class; 25-21 Upper-Middle Class; 20-16 Middle-Middle Class; 15-11 Lower-Middle Class; 10-5 Lower-Lower Class and below 4 the destitutes. The score value is determined through such total scores of three major criteria—income, occupation and educational level of father/

guardian of the retarded child as per Kuppuswamy's scale for measurement of socio-economic status. This scale has been evolved by the author pertaining to Indian conditions. Most of our respondents fall under the middle-middle class and lower-middle class of socio-economic status. But for showing relationship of the variables of income, education and occupation (also the determining factors of Kuppuswamy's scale) the variable of caste have been used separately for establishing dichotomous relationship. These items are taken as independent variables. This scale is used in this research only to establish the validity of the socio-economic status of the samples. The socio-economic status based on the value of this scale has not been used as an unified variable.

Matching Variables

The family conditions of the abovementioned two groups are compared on the basis of the following matching variables:

(a) Age of one retarded child (*N* for retarded child)
(b) Same age of one normal child (*X* for normal child)
(a) Parental age of *N*
(b) Parental age of *X*
(a) Income status of *N*
(b) Income status of *X*.

Tools and Techniques for Collecting Data

In the present study two types of data have been used:

(i) *Primary data concerning the interview*: Interview schedules have been used and information gathered by personal interview method. Two respondent groups have been chosen as mentioned above.

(ii) *Secondary data collection* : By case history records. The social workers and psychologists of the above-mentioned institutions maintain records of all the patients.

In these records the following information of the samples was available—their family structure, educational background, socio-economic status, type of family, religion, number of members, marital relations of their parents, functional and dysfunctional achievements, mental health history, etc.

These documents have been compiled from the available above-mentioned sources in case of mentally retarded children, and by personal interview from the families of normal children.

Administration of the Schedule

If the questions are predetermined and the extent to which the interviewer can explore the answers given, is restricted by definite rules, such interview is called 'structured interview'.

In the present study the structured interview process was adopted because it is a more efficient tool for research than an unstructured one. At the end of each printed schedule a blank page was left for the investigator to write down in detail any important information about the family or about any individual member of the family which was not covered in the questionnaires.

Pilot Study

After preparing the interview schedules a pilot study was performed by taking 10 respondents from both the respondent groups. The purpose of the pilot study is quite distinct from that of the main survey. The pilot survey was designed primarily as an exercise in methods of asking questions and in recording answers.

The pilot study revealed some difficulties with the result a few questions were modified. Though in some cases answers to questions were not readily forthcoming, in most of the cases the necessary cooperation by the respondents was given unhesitatingly.

Survey Instruments

The principal instruments for investigation were a set of two schedules which were filled by the author during the period of September 1972 to March 1973.

Two sets of schedules were developed as follows :

Schedule 1: (*For family conditions of mentally retarded children*):

These included (i) house address, (ii) parental name and age, (iii) occupation of parents, (iv) total income of the family, (v) type of family, (vi) religior, (vii) caste, (viii) migration, (ix) mental health history of the family, (x) untimely death of any member of the family, (xi) functional and dysfunctional achievement in the family, (xii), nature of treatment with the female members,

(xiii) age of the child, (xiv) sex of the child, (xv) nature of the child—aggressive, cooperative or jealous, (xvi) delinquency. A report of treatment about mental retardation of the child, (xvii) how family is affected with the retardation of the child, (xviii) which treatment resulted any improvement in the child, (xix) intelligent quotient of the child, etc.

Schedule 2: (*For family conditions of normal children*) :

These included (i) home address, (ii) parental name and age, (iii) occupation of the parents, (iv) total income of the family, (v) type of family, (vi) religion, (vii) caste, (viii) migration, (ix) mental health history of the family, (x) untimely death of any member of the family, (xi) age of the child, (xii) sex, (xiii) functional and dysfunctional achievement in the family, (xiv) nature of treatment with the female members, (xv) nature of the child—aggressive, cooperative, jealous, (xvi) delinquency, etc.

Tabulation and Analysis of Data

Collected data were scrutinised and edited. Tabulation work was then started. For analysing and representing the data, it was decided to rely upon the frequency tables. Tabulation was done in such a way so that the data revealed internal logic and order. In the tables representing the frequency distribution of different variables, the method for measuring the limits of the class intervals in a frequency distribution, is of exclusive type. This method is used in describing the tables of the variables of occupation and parental age only and the rest of the frequency tables are of simple type.

No causal design was established for the findings. The findings in the proceeding chapters reveal concomitant relation of two variables—the social conditions and mental retardation. The research pools were not competent enough to establish causal relationship between these variables. What is found is only correspondence of (a) *set of social conditions found,* and (b) *with the occurrence of mental retardation.*

The corresponding variables may prove the working hypothesis relating to the environmental factor as significant variables in cases of mental retardation.

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3

Composition of the Family Background

THE following were the characteristics of the family background of the mentally retarded and normal children :

Total number of the families of the mentally retarded children	...	75
Total number of the families of the normal children	...	75

Age Group of the Parents of Normal and Mentally Retarded Children

TABLE 1

Age group of the fathers of mentally retarded children

Age in years	*Number of fathers*	*Percentage*
Below 20	—	—
20-30	2	2.67
30-40	37	49.33
40-50	23	30.60
50-60	11	14.66
60-70	2	2.67
Total	75	100.00

The Table indicates that major number of the fathers of the mentally retarded children fall in the age group of 30-40 years (49.33%).

TABLE 2

Age group of the mothers of the mentally retarded children

Age in years	*Number of mothers*	*Percentage*
Below 20	—	—
20-30	14	18.67
30-40	38	50.66
40-50	21	28.00
50-60	2	2.67
60-70	—	—
Total	75	100.00

The above Table indicates that majority of the mothers of mentally retarded children also fall in the age group of 30-40 years (50.66%) like fathers.

As mentioned in Chapter 2 of Research Design, one of the matching variables between the two groups (i.e., the group of mentally retarded children's families, and the group of the normal children's families) is the parental age; so the normal children's parents were sampled out almost from the same age group as shown in Tables 3 and 4.

TABLE 3

Age group of the fathers of the normal children

Age in years	*Number of fathers*	*Percentage*
Below 20	—	—
20-30	2	2.67
30-40	34	45.33
40-50	26	34.67
50-60	10	13.33
60-70	3	4.00
Total	75	100.00

TABLE 4

Age group of the mothers of normal children

Age in years	*Number of mothers*	*Percentage*
Below 20	—	—
20-30	14	18.67
30-40	44	58.66
40-50	14	18.67
50-60	2	2.67
60-70	1	1.33
Total	75	100.00

Table 4 reveals the position that the maximum number of mothers of normal children come from the age group of 30-40 years (58.66%).

Socio-economic Class and Mental Retardation

It has long been recognized that children's IQs tend to vary with the socio-economic status of their families. Numerous investigators have found that children's scores on conventional intelligence tests are substantiallly correlated with such socio-economic factors as the father's occupation, the parents' education and the family income. It has been repeatedly noted that mildly retarded children tend to come from lower class background, while severely retarded children come from homes which nearly resemble a cross-section of the general population.[1] Baird and Scott[2] found a significant positive relationship between the intelligence of the mother and the number of her siblings which was marked in the lower social classes but insignificant in the upper classes. To exemplify the kind of interaction which may take place between such variables, it is quoted as follows:

In the lower income group where money is scarce, the more intelligent parents will be more likely to use their limited resources to the best advantage in an effort to give their children the best chance within their power. They will thus limit the number of children to ensure that they get good and healthy surroundings. The daughters will, therefore, tend to grow to their full height and they will be healthy. Since the parents are above average intelligence for their class, the daughters are likely, on the average, to be more intelligent. In addition, their superior health and home background will probably increase their chance of doing well in the intelligence test. Where the parents are less intelligent there is less likelihood that the size of the family will be so carefully controlled so that there will be less money to go round and as a result diet and living conditions will be less good. The daughters will, therefore, not grow to their full potential height and will tend to be small. The daughters, like the parents, will have a greater chance of being of less than average intelligence. This might explain why, in social classes III to V but not in classes I and II, small women tend to come from large families and be less intelligent than tall women.[3]

There are so many researches which reveal that there is an inverse relationship between socio-economic class and mental retardation.

In the present study most of the mentally retarded children are found in the lower income group.

Socio-economic Status of the Respondents

To identify the social status of the respondents under study, Kuppuswamy's[4] standardized socio-economic status measurement scale is employed keeping in view the head of their household as the bearer of the component of the socio-economic status. The class position is determined through the status score values which vary as follows: 29-26 elite class; 25-21 upper-middle class; 20-16 middle-middle class; 15-11 lower-middle class; 10-5 lower-lower class and below 4 the destitutes. The score value was determined through sum total scores of three major criteria; income, occupation and educational level of fathers/guardians as per Kuppuswamy's scale for measurement of socio-economic status and it can be seen as below.

(*i*) *Income*: The first element in determining the status criteria of the respondents, is monthly income of fathers/guardians which can be seen in Table 5.

TABLE 5

Monthly income of fathers of the mentally retarded children

Income group in rupees per month	*Score*	*Number of respondents*	*Percentage*
Above 1,000	12	4	5.33
750-999	10	—	—
500-749	6	13	17.34
300-499	4	10	13.33
101-299	3	36	48.00
51-100	2	12	16.00
Below 50	1	—	—
Total		75	100.00

The respondents with income group of 101-299, possessing 3 points in score value, constituted the maximum number.

(ii) *Occupation*: The second element in determining the socio-economic status criteria was occupation of fathers/guardians which can be seen in Table 6.

TABLE 6

Occupation of fathers of the mentally retarded children

Occupational categories	*Score*	*Number of respondents*	*Percentage*
Profession (doctor, advocate, etc.)	10	3	4.00
Semi-professional	6	6	8.00
Clerical, shop-owner	5	36	48.00
Skilled-worker	5	3	4.00
Semi-skilled worker	3	10	13.33
Unskilled worker	2	17	22.67
Unemployed	1	—	—
Total		75	100.00

The fathers/guardians of the retarded children are mostly in the clerical or shop-owner occupational category. Next major number occupied by the fathers are of unskilled workers occupational category.

(iii) *Education*: The third element in constituting the status score is educational level of fathers of the retarded children which can be seen in the following table.

TABLE 7

Educational level of fathers of the mentally retarded children

Level of education	*Score*	*Number of respondents*	*Percentage*
Professional degree, post-graduation and above	7	8	10.66
B.A./B.Sc.	6	19	25.34
Intermediate	5	1	1.34
High School	4	6	8.00
Middle School completion	3	6	8.00
Primary School/Literate	2	15	20.00
Illiterate	1	20	26.66
Total		75	100.00

The educational level of the majority of fathers in the present study who were under the category of illiterate have the percentage of 26.66. Next comes the place of B.A/B.Sc. level of education having the percentage of 25.34. Then come the fathers in the category of primary school/literate having the percentage of 20.00. Educational attainment is an important factor for rising in social status. The fathers of the retarded children are mainly undergraduates. This hampers their chances of upward social mobility.

As mentioned earlier, the Kuppuswamy scale has been used for measuring the socio-economic status. The status of respondents was decided by counting the score value of the respondents as indicated in the following table.

TABLE 8

Socio-economic status of the parents of the mentally retarded children

Score value	*Number of respondents*	*Percentage*
26-29	2	2.6
16-25	14	18.6
11-15	26	34.6
5-10	33	44.0
Below 4	—	—
Total	75	100.00

The score value is the sum total of scores of the three aspects—educational level, occupation and income of fathers of the retarded children. The above figures indicate that 44% of the respondents are under the score 5-10, which is assumed as lower-lower status score under the present study. Respondents of extreme lower class (destitutes) possessing score below 4, have not been found in this study; 34.6% of the respondents are under the score 11-15 which is assumed as lower-middle class status score. Of course, 18.6% of the respondents are found from the category of 16-25 (score) which constitute the middle-middle class status. Hence, it can be said, from the study of the above figures, that the respondents constituting the maximum number are from the lower socio-economic strata of the society.

This socio-economic status is used in this research only to establish the validity of the socio-economic status of the samples. The socio-economic status on the value of this scale has not been used as an unified variable. Hence the independent variables of the present research as the variable of occupation, income and education (also the determining factors of Kuppuswamy's scale) discussed in the proceeding chapters have been arranged in a

different way according to the advantage of the investigator and it differs with the arrangement of the above-mentioned variables of Kuppuswamy's socio-economic scale.

Caste/Community Background

The caste/community background of the mentally retarded and normal children is given in the following tables:

TABLE 9

Caste/Community (Mentally retarded group)

Caste/Community	*Number of families*
Brahmin	10
Kshatriya	9
Vaishya	34
Lower castes	15
Muslim	4
Christian	3
Total	75

The families of mentally retarded children was found to be mainly of Vaishya caste.

TABLE 10

Caste/Community (Normal group)

Caste/Community	*Number of families*
Brahmin	14
Kshatriya	11
Vaishya	20
Lower castes	24
Muslim	6
Total	75

Caste composition of samples collected for normal children was found to be mostly from lower castes.

Mental Health History of Parental Side

The mental health history of the families of mentally retarded and normal children analysed by the investigator can be seen in Table 11.

TABLE 11

Mental history of parental side (Retarded group)

	Normal	*Mentally ill*	*Total*
Number of fathers	63	12	75
Number of mothers	69	6	75

The mental health history of the parents of the mentally retarded children in this study revealed the figure of 63 fathers and 69 mothers having a normal history, whereas 12 fathers and 6 mothers have the history of mental illness.

TABLE 12

Mental health history of parental side (Normal group)

Parents	*Normal*	*Mentally ill*	*Total*
Number of fathers	75	—	75
Number of mothers	74	1	75

The sample of normal children could not be found to have any history of mental illness of the parents except one case of mother having such history of illness in the family.

Possible Factors of Sibling Order and Mental Retardation

Birth order, family size, age of parents and socio-economic factors are closely inter-related.

Generally it is said that there is an increased risk of maldevelopment after the third or fourth pregnancy and some studies have indicated an increased risk with the first.[5] The data indicate that a correspondence exists between parity (parity refers to birth order of the child or more precisely to the number of the mother's pregnancies) and deficiencies of central nervous system, but the relationship is not so pronounced as that between maternal age and such deficiencies.

TABLE 13

Sibling order and mental retardation

Sibling order	*1st*	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*8th*	*Total*
Number of retarded children	27	18	11	6	3	3	4	3	75
Percentage	36	24	14.67	8	4	4	5.33	4	100

In the present study it has been found that the majority of children who are mentally retarded are first born, and the next higher number belongs to second in the birth order.

The sibling order of mentally retarded children compared with the educational standard of the parents indicates the first born children to be amongst the higher educated group of parents. The first born retarded children of graduate and post-graduate parents was 12 in number, compared to 10 of primary and junior high school standard of parents.

TABLE 14

Education—sibling order—mental retardation

Education	*1st*	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*8th*	*Total*
Primary/ Junior High School	10	4	2	3	1	1	—	1	22
High School and Inter-mediate	3	2	1	1	1	—	3	1	12
Graduate and Post-graduate	12	9	3	2	—	—	—	—	26
Illiterate	2	3	5	—	1	2	1	1	15
Total	27	18	11	6	3	3	4	3	75
Percentage	36	24	14.6	8	4	4	5.33	4	100

TABLE 15

Education—sibling order—and normal children

Education	*1st*	*2nd*	*3rd*	*4th*	*Total*
Primary to Junior High School	10	8	3	—	21
High School/ Intermediate	4	3	3	4	14
B.A./M.A.	11	3	8	—	22
Illiterate	11	3	4	—	18
Total	36	17	18	4	75
Percentage	48	22.67	24	5.33	100

In case of normal children, variable of education to the sibling order of the child reveals data almost similar to that of mentally retarded children.

In the present study it has been found that majority of the mentally retarded children are first and then second born. But in earlier studies by some great researchers which are being discussed hereunder, it has been found that intelligence quotient of children decreases as siblings increases.

Lilienfeld and Passamanick (1956)[6] are of the opinion that the risk of maldevelopment of children becomes higher and higher after the third or fourth pregnancy. They studied 1,107 mentally retarded children in Baltimore and 1,107 control children chosen from the hospital records. Risks were particularly high in young mothers who had three children before they were twenty and in mothers who were bearing their first or second child after the age of thirty-five. Studies like these indicate some sort of physiological process.

But the Scottish Council for Research in Education[7] clearly indicates that IQ decreases as number of siblings increases. But it should be noted that no cause and effect sequence has yet been clearly established in the number of mothers' pregnancies and mental retardation.

According to Nisbet and Entwistle[8] even the relationship between birth order and intelligence might be conceived to depend on environmental factors.

Hence the exact cause which can be taken as a factor for retardation cannot be demonstrated.

The Caste Cultural Group and Mental Retardation

The facts of this study point out the significance of environmental factors in the incidence of mental retardation. In terms of Indian structural and cultural traditions, consisting of environmental factors, it can be traced with the caste position of the mentally retarded children. A caste is an ethnic as well as a cultural group; it is 'a total structure'. Being total structure, the caste determines individuals' life situation, life chances and learning process.

TABLE 16

Caste/Community structure—sibling order—mental retardation

Caste/ Community	*1st*	*2nd*	*3rd*	*4th*	*5th*	*6th*	*7th*	*8th*	*Total*
Brahmin	1	2	4	1	1	—	—	1	10
Kshatriya	2	2	3	1	1	—	—	—	9
Vaishya	19	8	1	2	1	2	—	1	34
Lower castes	4	5	2	2	—	1	—	1	15
Muslim	—	—	—	—	—	—	4	—	4
Christian	1	1	1	—	—	—	—	—	3
Total	27	18	11	6	3	3	4	3	75
Percentage	36	24	14.67	8	4	4	5.33	4	100

TABLE 17

Caste/Community structure—sibling order—normal child

Caste/Community	*1st*	*2nd*	*3rd*	*4th*	*Total*
Brahmin	7	1	4	2	14
Kshatriya	7	3	—	1	11
Vaishya	8	5	7	—	20
Lower castes	13	5	5	1	24
Muslim	1	3	2	—	6
Total	36	17	18	4	75
Percentage	48	22.67	24	5.33	100

The caste variable when taken into consideration for the study of seventy-five mentally retarded children, highest number of thirty-four belonged to Vaishya Hindu community of whom twenty-seven were in the 1st and 2nd sibling order, whereas next in the 1st and 2nd sibling belonged to lower castes.

Income, education and age of the child being constant, the caste variation of normal children was not found to be of any effect.

But in the case of mentally retarded children, Table 16 indicates that mostly they come from Vaishya caste. The families under this caste belong to lower income level. The Vaishya community is mainly a community of traders, and that too mainly limited to trading and not manufacturing. The socio-economic status of the families under study in the part of the State (Eastern UP), has never been found to be having any higher educational pursuit except trying to earn money by trading, lending and such other methods. They are not big industrialists and do not have high motivations. They follow their hereditary occupation of shopkeeping. They would not like to spend money on higher pursuits. The children usually acquire the business tactics from the family ethos as they had also been the traditional village 'mahajans' (moneylenders). The members of other castes do not interact favourably with this caste. It is isolated, crazy after money, unmindful of higher standards of life. It earns but fails to spend. Obviously, the lower section of Vaishya caste breeds a culture of sluggishness and dullness. The caste endogamy practice makes the probability of retardation still higher in the caste group. However, it may be said that due to preoccupation in business the parents of this community might be thinking of bringing their children up for their business work and such conditions might in turn create a negligence resulting in a case of perceiving mental retardation.

Families Having Distorted Heritage

The study reveals that a good many number of families of mentally retarded children have a history of disorders.

Another peculiarity, generally found in their family history is of premature deaths. The total number of such cases in the case of mentally retarded children is revealed by the following tables.

Taking the factors of income, education and age group of the child and the parents as common between mentally retarded child and the normal child, the comparative study reveals the following result.

Premature Deaths

An attempt was made to find out the data concerning the premature deaths in the families of retarded and normal children. Sometimes untimely death of parents causes havoc in the family life. Analytical tables below give the concerning data.

TABLE 18

Premature death of ancestors—mentally retarded children's family—normal children's family

Percentage of history of premature deaths in the families		*Percentage of history of matured deaths in the families*	
Normal children	Retarded children	Normal children	Retarded children
1 (1.33%)	23 (30.67%)	74 (98.67%)	52 (69.33%)

The above table indicates the history of such premature deaths which might be one of the significant factors for creating a probable condition for retardation, as the result is not quite insignificant.

There are other factors of irregularities in the history of the family of mentally retarded children which can be termed as shocks from incidences of having step-relations, deaths, neurotism, division of family property as a consequence of rifts. Such history of shocks in the family has also been found in this study.

The income, education and age factors being common, a comparative result of the study about mental retardation and normal children makes out the following results.

History of Shocks

Sometimes division of family property, step relations, neurotism also create problematic situations in the family. The following table gives such information for both the groups (normal children's family and retarded children's family).

TABLE 19

History of shocks in the ancestors

Percentage of history of shocks in the families in positive. (Yes)		*Percentage of history of shocks in the families in negative. (No)*	
Normal children's family	Retarded children's family	Normal children's family	Retarded children's family
15 (20%)	30 (40%)	60 (80%)	45 (60%)

The table signifies that in case of normal children 20% of their parents received shocks (due to incidence of having step-relations, neurotism, division of family property) in their life period whereas in case of the parents of mentally retarded children the incidence is just the double, i.e. 40%.

Conclusion

The study reveals that many homes in this group are characterised by adverse physical and social conditions (variables). The abject misery and the dismal social and emotional tone of these families is astonishing. The intellectual as well as general status are both very low in these families. The parents are uneducated. Their homes are typically in slum areas, are very small, ill-heated in winter and often lacking in such basic amenities as running water, toilets, etc. Hunger is a constant companion of the children who are scantily clothed, through all seasons.

There are other researches too which verify the above picture of the families of the retarded children.

Saenger (1960)[9] says, "A high proportion of these homes, moreover, are characterised not only by physical deprivations but by emotional poverty as well. Some of the parents stay together only because there is no other place to go rather than because of mutual affection or a strong desire to raise a family. Other homes are broken by desertion or occasionally by divorce".

Halperin (1946)[10] has written, "The diagnosed child is very likely to differ very little from his parents and siblings in this respect; it is not at all surprising to find several family members who are more severely mentally handicapped than the diagnosed boy or girl."

In the present study it was found that poor socio-economic conditions correspond with mental retardation. This factor is added by a caste strata of lower section of business men of Vaishya community. Some history of disorder in the family were also found to be a probable contributory cause to such cases of mental retardation of the children, the socio-cultural factors of dullness associated with Vaishya community may be responsible for mental retardation.

As mentioned earlier we have not established any causal design of our findings. The findings in the chapters reveal concomitant relation of two variables—the social conditions and mental retardation. Our research pools were not competent enough to establish causal relationship between these variables. What is found is only correspondence of (a) a set of social conditions found, and (b) with the occurrence of mental retardation.

The corresponding variables may prove the hypothesis relating to the environmental factor as significant variables in cases of mental retardation.

The sibling order is one of the important factors of mental retardation. Usually it is the later siblings who are found to be retarded but our findings do not correspond to this commonly held viewpoint. Of the samples, 27 were first born, 18 second born and 11 third born children.

A high frequency of cases of mental retardation is found in the first born. This may be due to the factor of 'unwantedness' with the 1st born while the parents were quite young, deeply in love

and inexperienced in child rearing. In certain cases the mother has to leave the child in the care of an untrained maid servant or in-laws. She has to attend regular employment duties or domestic duties. It is an usual practice in lower-middle class families to administer certain drugs (crude opium) to babies for sound sleep so that the couple may not be disturbed during the nights. The general practice of unwantedness deprives the child from normal and physical growth.

The findings reveal that the environmental factors, especially the cultural factors, are significantly found to be associated with the phenomenon of mental retardation in the sample under study.

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4

The Importance of Marital Adjustment and the Offspring

A human being's dependence on the social environment begins long before he is born; with the folk ways and mores governing his parents' courtship and marital selection, with the customs concerning pregnancy and with the whole system of cultural practices when he was born. Conception took place in a socially defined situation important for the child's subsequent status. Techniques of prenatal care in the community affected his chances of being born and of being healthy. In sum the social circumstances preceding his birth not only made his life possible but also laid down to a great extent the kind of life he was to lead. The mother and the father are the first and in many ways the most important socialising agents. Hence the marital adjustment between the parents themselves play very important role for the socialisation of their offsprings.

In the broadest sense, disturbance in marital adjustment may be thought to include any sort of non-harmonious functioning within the family. Thus, it may include not only the tensions between husband and wife, but those arising between children and parents as well. Therefore, our discussion of the marital adjustment will be mostly confined to the disruptions of the marriage relationship occasioned by tensions between husband and wife. The legal or social function of the normal family life may be maintained even when these personal relationships are at a minimum level. A family may continue to live under the same roof because of religious beliefs or economic or social motives which may influence the husband and wife to live together, from which love and affection

have since long disappeared. "In some cases the outward family life may be maintained while affectionate interests are satisfied elsewhere."[1] At the same time we should not forget that every normal family experiences conflicts which it is expected to overcome.

"Every man and woman enters marriage from a separate background, with different ideas and attitudes borne out of his or her own experiences. Each possesses a scale of values developed out of a particular social group. Under the circumstances, it is not surprising that distinctive personality traits of the one may unconsciously or consciously irritate the other. Only by integrating the husband's and wife's individual desires and attitudes can a successful family life be achieved with a harmonious functioning of the interacting personality."[2]

Joint Families and Mental Retardation

In India joint families are more prevalent. "In one of the surveys conducted among 114 couples in Uttar Pradesh who married under the Special Marriage Act, 1954 it was found that 92 out of 114 respondents had some irritants in their married life; they were 54 husbands and 38 wives and the rest did not answer this question. Among these the most frequently reported irritants in the married life of these respondents were those who were irritated due to the attitudes and temper of spouse. These were the greatest source of annoyance for the husbands and the second greatest source of annoyance for the wives. Inlaws became the next greatest source of irritation in the marital life of the couples."[3] It has been found in study that many of the married couples committed suicide due to conflict with their inlaws.

An analysis of 37 female mental patients (10% of the total institutional female population) revealed that most of them had unhappy relations with their spouse and inlaws, especially with mother-in-laws."[4]

In the family children are accustomed to look to their parents for affection and security. The sudden interruption of this relationship in the primary group is a shock to the child's developing personality. His position may take various forms one of which may be mental retardation.

Marital status of the parents contribute much to the proper rearing of the children in the family. The family is the primary group for socialisation in which the main roles are played by the parents. Parents having healthy marital relationship reflect a healthy image to their children which helps the children to develop physically and mentally. But if for any reasons the married life of the parents are not successful, the children may be taken as dejected symbols of frustration, unwantedness and burdens in the family. It seems that in such conditions more chances of maldevelopment of the brain can be found.

Here the attempt has been made to deal with the few points about the marital adjustment of the parents of mentally retarded and normal children. The problem of marital adjustment is seen to be of significance in the joint families.

Majority of the families of the mentally retarded children were found in this study to be joint families. Tne following table reveals the factual position.

TABLE 20

Comparative data showing structure of families of normal and mentally retarded children.

	Families of mentally retarded children		*Families of normal children*	
	Number	Percentage	Number	Percentage
Nuclear families	26	36.6	57	76
Joint families	49	65.33	18	24
Total	75	100.00	75	100

The total number of joint families are 49 out of 75 families, i.e., 65.33% in case of retarded children whereas the normal children were mainly found to be belonging to nuclear families, i.e., 57 families out of 75 families (76%).

Keeping in view the above facts which have been revealed by this study, i.e., there is only 24% of the families of normal children found to be joint in nature and the remaining 76% of the families are of nuclear type, the present author has not correlated the study of joint families for normal children with the variables of caste, income, education and occupation. But in case of retarded children they have been examined hereunder.

Education—mental retardation—joint families

When the variable of education is taken into consideration and it has been correlated with the family structure of the mentally retarded children, the results are as per the Table given below :

TABLE 21

Education—mental retardation—joint families

Educational level	*Joint families*	*Nuclear families*	*Total*
Primary to Junior High School	11	11	22
High School to Intermediate	8	4	12
Graduates and Post-graduates	16	10	26
Illiterate	14	1	15
Total	49	26	75
Percentage	65.33	34.67	100

Income—mental retardation—joint families

In lower socio-economic strata, a marriage which is based exclusively upon the dreaming and extravagant vagaries of romantic idealism without consideration of financial and social position, cultural dissimilarities and parental objections, faces a tremendous handicap. The couple is bound to believe now that marriage is a practical and serious relationship not a romantic interlude. When the variable of income is correlated with the joint families of mentally retarded children, the findings reveal the following structure:

TABLE 22

Income—mental retardation—joint families

Income per month	*Joint families*	*Nuclear families*	*Total*
100—400	37	16	53
400—800	8	7	15
800—1200	4	3	7
Total	49	26	75
Percentage	65.33	34.67	100

The Table indicates that most of the retarded children (37 out of 49) are belonging to the joint families which fall in the income group of 100-400 rupees per month. Eight joint families out of 49 joint families of mentally retarded children are in the income group of 400-800 rupees per month. The joint families earning more than 800 rupees per month have smallest number of mentally retarded children, that is, only 4 out of 49 families.

As the above Table reveals, most of the joint families of retarded children are in the lower income group, which shows that parents and other elderly family members are always worried for making both ends meet. Long continued worry over financial matters is not conducive to healthy marital relations. Poverty is,

of course, a relative term. An income which a middle-class family defines insufficient may be enough for a lower class family. A person whose income is not enough to meet the necessities of life in a particular position may affect his temper. His wife and other members of the joint family may be sympathetic, but they are equally worried. The victim of continual family tension is often the child and the continual indifference or neglect hampers his further mental development.

Occupation—mental retardation—joint families

Closely related to economic tensions are those which develop out of the peculiar nature of the day's work. The mobility necessary to a particular line of work is often a source of family tension. Sometimes they become so accustomed to living apart that they get on each other's nerves when they are together for a long time. Similarly, unstable occupation (from store clerk to the insurance business or from salesman to a washerman), the continual readjustment and lean income period inevitably entail family hazards. Burgess and Cottrell[5] found that frequent change of position is correlated with low scores in marriage adjustment.

The third variable, i.e., occupation is correlated with the joint families of mentally retarded children and it gives the following results.

TABLE 23

Occupation—mental retardation—joint families

Occupation	*Joint families*	*Nuclear families*	*Total*
Business	35	8	43
Service	10	17	27
Agriculture	4	1	5
Total	49	26	75
Percentage	6 5.33	34.67	

Most of the joint families of mentally retarded children are having the occupation of business, i.e., out of 49 families 35 are occupied in business occupation. Next to this occupation, the occupation of service is found in 10 joint families of mentally retarded children. Only 4 joint families of such children are involved in the agricultural occupation out of 49 joint families.

In the present study it has been found that mostly the parents of joint families of retarded children are educated at the level of graduation or even at post-graduate level. No amount of income in a business to a man of literary and academic taste can bring contentment. Disgusted with the business world, which he feels is prostituting his intelligence, he may not be in the proper psychological frame of mind to enjoy the social relationship which his family brings. There arises a conflict between his ideals and practices which may easily be a source of friction in the family.

The next major group of parents of retarded children is totally illiterate. Probably due to lack of education and fully occupied with their business activities, these parents hardly care for their families which in turn may result in a callous attitude which makes them incapable of enjoying life or allowing others to enjoy it.

Caste/Community—mental retardation—joint families

When the fourth variable of caste/community is correlated with the joint families of mentally retarded children, the study gives the following results.

Table 24 reveals that most of the families of mentally retarded children, i.e., 24 joint families out of 49, are of Vaishya caste structure. In Kshatriya there are only 4 joint families having mentally retarded children. Next the highest number of mentally retarded children's joint families are of Brahmin caste, i.e., 9 such joint families out of 49 joint families are Brahmins. Only 7 joint families are of lower castes. There are only 3 families found in Christian community out of which only one family is of joint in nature. In Muslim community there are 4 joint families having mentally retarded children.

TABLE 24

Caste/Community—mental retardation—joint families

Caste/Community	*Jotnt families*	*Nuclear families*	*Total*
Brahmin	9	1	10
Kshatriya	4	5	9
Vaishya	24	10	34
Lower castes	7	8	15
Muslim	4	—	4
Christian	1	2	3
Total	49	26	75
Percentage	65.33	34.67	100

Quality of Marital Life in Joint Families of Mentally Retarded Children

As discussed earlier the mentally retarded children have been found mostly from joint families, and that being so, the issue of nature of life of the joint families is being discussed in the study.

As the normal children were mostly from the nuclear families, this study has not gone into the cases of joint families of normal children. In our present social order when old family groupings and combinations are breaking into fragments due to process of industrialisation and sense of urbanisation, joint families are generally linked with rural units and units of lower economic status. Of course, few families still exist jointly by ideological bonds but they are also breaking up into nuclear families. However, as in this study most of the cases of mental retardation were found to belong to joint families, for finding a correlation of such families with the nature of life, a study was required.

The present work analyses the marital nature of such joint families of mentally retarded children hereafter.

EDUCATIONAL LEVEL AND QUALITY OF MARITAL LIFE IN JOINT FAMILY SETTINGS OF MENTALLY RETARDED CHILDREN

With the standard of education as the variable, the quality of marital life of such joint families was examined and it was revealed that there are mostly quarrelsome or tragic marital life and of them highest number of such joint families come from higher educated group and then from illiterate group. The Table of examining the marital nature of the parents of the families with the variable of education is given below.

TABLE 25

Educational level of respondents and quality of marital life in joint families

Educational standard	*Happy*	*Unhappy*	*Moderate*	*Quarrelsome*	*Tragic*	*Other*	*Total*
Primary to Junior High School	—	3	1	2	5	—	11
High School/ Intermediate	1	2	—	2	3	—	8
Graduates and Post-graduates	2	2	4	6	1	1	16
Illiterate	—	2	—	2	10	—	14
Total	3	9	5	12	19	1	49
Percentage	6.12	18.3	10.2	24.4	38.6	2.04	100

The marital life of respondents (N's fathers) is almost a failure in terms of adjustment. The negative adjustment seems to be high among them. They are unhappy (18.3%), quarrelsome

(24.4%) and tragic (38.6%). The positive marital adjustment is found in less numbers. Only 6.12% could find themselves happy. The moderately happy-unhappy conjugal pair are 10.2% which is a fringe point, often shifting towards negative adjustment. The figures tell a story of marital failure of the parents of the retarded children. The quality of marital life seems to be quite meaningfully related with the phenomenon of mental retardation in Indian joint family setting. We are not sure of its causal efficiency as a corresponding factor in mental retardation but it seems to be relevant in understanding the social factors of mental retardation.

Income and Quality of Marital Life in Joint Family Settings of Mentally Retarded Children

These joint families of mentally retarded children when compared with the variable of income, the following findings are observed.

Table 26

Income—quality of marital life-joint families

Income Rs/month	*Happy*	*Unhappy*	*Moderate*	*Quarrel-some*	*Tragic*	*Others*	*Total*
100-400	2	6	2	10	15	2	37
400-800	—	1	1	3	2	1	8
800-1200	—	—	2	—	1	1	4
Total	2	7	5	13	18	4	49
Percentage	4.1	14.2	10.2	26.5	36.7	8.1	100

It was found that the lower income group, which is the maximum in number, of such families had maximum number of cases of tragic or quarrelsome marital life. Rather the tragic or

quarrelsome marital life are more than others in case of every income group of such joint families.

OCCUPATION—QUALITY OF MARITAL LIFE IN JOINT FAMILIES OF MENTALLY RETARDED CHILDREN

When the quality of marital life of the parents of mentally retarded children (mostly belonging to joint families) is compared with the variable of occupation, it revealed the following data.

TABLE 27

Occupational category—quality of marital life—joint families

Occupation	*Happy*	*Unhappy*	*Moderate*	*Quarrelsome*	*Tragic*	*Others*	*Total*
Business	2	4	6	9	13	1	35
Service	—	1	1	2	5	1	10
Agriculture	1	2	—	1	—	—	4
Total	3	7	7	12	18	2	49
Percentage	6.1	14.7	14.2	24.4	36.7	4.08	100

The joint families of mentally retarded children were also found to be mostly from the occupation of business category as it was found in all other cases as discussed earlier, and of them also most of the families were tragic or quarrelsome.

CASTE/COMMUNITY—QUALITY OF MARITAL LIFE IN JOINT FAMILIES OF MENTALLY RETARDED CHILDREN

When the variable of caste/community is compared with the marital status of the parents of retarded children in their joint family structures, the following data are found.

TABLE 28

Caste/Community—quality of marital life—joint families

Caste/Community	*Happy*	*Unhappy*	*Moderate*	*Quarrelsome*	*Tragic*	*Others*	*Total*
Brahmin	1	1	1	1	3	2	9
Kshatriya	—	1	1	—	2	—	4
Vaishya	1	3	4	2	6	8	24
Lower caste	—	1	—	1	3	2	7
Muslim	—	1	1	—	2	—	4
Christian	—	—	1	—	—	—	1
Total	2	7	8	4	16	12	49
Percentage	4.08	14.2	16.3	8.1	32.6	24.5	100

The caste/community composition of such families, when compared with the marital nature of the parents of such families, reveals that maximum number of parents are from Vaishya caste structure and they are also plagued with an unhappy and quarrelsome marital life. The collection of data on 49 joint families of the mentally retarded children reveals that the joint families occupied in service occupation also are mostly unhappy and the joint families occupied in agricultural occupation also show the unhappy characteristics of marital life.

In all the above cases studied, it was found that nature of the marital life of the parents of the mentally retarded children was generally disharmonious and unhappy.

An attempt was made to acquire the reasons for the unhappy nature of the joint families of mentally retarded children. The following reasons were found :

Disparities in attitudes and values result in tensions in the family which may make life together intolerable to both. Hornell

and Hart observes, "Marriage is more than a sex relationship with prescriptions for caring for offspring. In fact, it is a functional relationship between two personalities involving some varied items as habits, friendships, aversions, property, ideals, attitudes, purposes and potentialities. When husband and wife love each other, their two personalities function more effectively, because of the marriage relationship. When husband and wife thwart each other, or attempt to enslave each other the marriage is a disaster."[6]

Some of these tensions arise out of personality structures of the mates and make them more or less incompatible at the outset. These personality characteristics may include temperament, philosophy of life (disparity of values), personal behaviour patterns and psychopathic personalities which in the beginning may be hidden in the romantic fallacy. The other tensions may arise out of economic and occupational situations, cultural differences (including education), differences in social status, mattess of ill-health, and interference of in-laws. So both the personal and impersonal factors of tensions are found in this study.

In few cases it has been found that husbands and wives come from different cultural backgrounds. So they find it difficult to adjust. Burgess and Cottrell found that "cultural background of both husband and wife to be one of the five groups of factors affecting family adjustment."[7]

In some cases ill-health of the spouse are important factors for making their lives monotonous. At the first instance, a sick wife or husband may conjure up a real emotion of sympathy. But long continued ill-health with its drain on the family budget, the irritability because of nervous tension may, however, become a source of many family problems. Lack of stimulating contacts, monotonous aspect of house work coupled with the husband's indifferent expression of affection may lead to her nervous break-down.

In the present study we find that the most important factor for creating tensions in the marital life of the joint families is the interference of in-laws. Parents are often imbued with ambitions and the desire for their children's happiness and consequently they frequently insist upon imposing their decisions on the reluctant children. They may insist that the daughter-in-law is too extravagant, or she is uncooperative, or she is unsuited to her task

as a mother. In countless ways their undue criticism may play havoc with a newly married couple.

Expectations from the Spouses

To many persons romantic love is the essence of all affectional function of the family. These persons enter marriage with ideas derived from many romantic sources like movies, popular magazines, etc. But the affectional function includes a variety of interpersonal relationships that are necessary if the individual is to develop into a socially adjusted human being. Thus, besides the sex attraction, sympathy and conjugal affection are other necessary important elements of affection which young persons do not realize at that stage. As Mr Thomas points out, "The wish for response is the basis of the affectional functions of the family. This sentiment is primarily related to the instinct of love and in the tendency to seek and give signs of appreciation in connection with the other individuals. The romantic love expects to seek and give signs of appreciation at all times and at all places. In fact, he confidently expects to devote his life to this enchanting activity and expectation that is approximately realized during the few weeks and months of marital intimacy. But the continuation of such a relationship ultimately decreases in intensity and satisfaction, unless supplemented by the calm pleasure of conjugal affection. During this period of decreasing romantic ecstasy, many persons begin to question about the validity of their marriage. They do not realize that romance is not every thing for all the successful unions."[8] Hence romance is not the only sound basis of marriage. Mr Landis points out, "Many divorces arise because the romantic expectations with which young people often enter marriage are frustrated by the unromantic realities of the marital situation. If these expectations could be modified in the direction of greater realism, a large number of marriages might conceivably be saved."[9]

In the present study an attempt was made to know the fulfilment of expectations from the partner—whether it was complete or mild or else—they were frustrated. The results of the investigation reveal that expectations were mildly fulfilled, and in few cases only they were frustrated.

EDUCATIONAL LEVEL OF PARENTS AND DEGREE OF EXPECTATION FULFILLED

The variation of educational standard of the families being taken into consideration, the investigation about the family of mentally retarded children shows the following data (Table 29).

TABLE 29

Educational level of respondents of retarded children and the degree of expectations fulfilled

Educational standard	*Completely fulfilled*	*Mildly fulfilled*	*Frustrating*	*Total*
Primary and Junior High School	2	12	8	22
High School/ Intermediate	1	6	2	9
Graduate and Post-graduate	4	17	10	31
Illiterate	3	10	—	13
Total	10	45	20	75
Percentage	13.33	60.00	20.67	100

In case of normal children's parents, when they were asked about the fulfilment of their expectations compared with the variable of education, we observed the findings as mentioned in Table 30.

In case of normal children mildly fulfilled expectations were found in 48 families, whereas there were only six frustrated families.

INCOME AND THE DEGREE OF EXPECTATIONS FULFILLED

The income variation being taken into consideration in the results of the investigation about the fulfilment of expectations from

TABLE 30

Educational level of the respondents of normal children and degree of expectations fulfilled

Educational standard	*Completely fulfilled*	*Mildly fulfilled*	*Frustrating*	*Total*
Primary+Junior High School	2	19	2	23
High School+ Intermediate	4	6	3	13
Graduate and Post-graduate Illiterate	13	8	—	21
Total	21	48	6	75
Percentage	28	64	8	100

TABLE 31

Income group of respondents of mentally retarded children and the degree of expectations fulfilled

Income (in rupees)	*Completely fulfilled*	*Mildly fulfilled*	*Frustrating*	*Total*
100-400	3	34	19	56
400-800	6	8	1	15
800-1200	1	3	—	4
Total	10	45	20	75
Percentage	13.33	60.00	26.27	100

the partners both in cases of retarded and normal children reveal almost the same results as in case of education. The Table 31 indicates the relevant data.

The facts stated in the table indicate that mostly the expectations of the parents are mildly fulfilled in case of the parents of mentally retarded and normal children, i.e., 60% and 64% respectively, and the other data are analysed in the above Table and the Table given below.

TABLE 32

Income group of respondents of normal children and the degree of expectations fulfilled

Income in (rupees)	*Completely fulfilled*	*Mildly fulfilled*	*Frustrating*	*Total*
100-400	9	42	2	53
400-800	7	6	2	15
800-1200	5	—	2	7
Total	21	48	6	75
Percentage	28	64	8	100

OCCUPATION AND THE DEGREE OF EXPECTATIONS FULFILLED

Occupation variable being taken into consideration the results of investigation about the fulfilment of expectations from the partners in both the cases of retarded and normal group reveals almost similar results as shown in Tables 33 and 34.

Of these total number of families 39 belong to business community in case of normal children and 47 of the same in case of retarded children. Out of 47 families of retarded children 20 families show the expectations being not fulfilled and so they are frustrated, whereas only 6 families in case of normal children are frustrated. Fulfilment of expectations whether it is mild or

TABLE 33

Occupational category of respondents of mentally retarded children and their degree of expectations fulfilled

Occupation	*Completely fulfilled*	*Mildly fulfilled*	*Frustrating*	*Total*
Business	7	28	12	47
Service	3	16	7	26
Agriculture	—	1	1	2
Total	10	45	20	75
Percentage	13.33	60.00	26.67	100

TABLE 34

Occupational category of respondents of normal children and degree of expectations fulfilled

Occupation	*Completely fulfilled*	*Mildly fulfilled*	*Frustrated*	*Total*
Business	12	24	3	39
Service	9	24	3	36
Total	21	48	6	75
Percentage	28	64	8	100

complete, is found in more cases of normal children's family than in the retarded children's family.

The analysis of the report signifies that the frustration or mildly fulfilled expectations were expressed by parents of the retarded children from the higher education group in maximum number. It may be quite possible that such parents for reasons of having education had some high ideas about family life, but they probably could not get it fulfilled due to maladjustments for reasons of economic conditions and also being in big joint families, etc.

In case of normal children, however, this result of having maximum number of mildly fulfilled expectations or being frustrated were found in case of lower educated or in uneducated group of parents. It may be possible that as most of the families were found to belong to lower income group and uneducated, oppressed by dire economic consequences they had hardly any time or resource to have a happy family life which resulted in their feelings of not having their expectations fulfilled. Of course, in case of normal children feeling of total frustration of their parents is negligible.

The caste variable has not been found to have any considerable effect on this issue of expectations from partners. It also showed the same results and they also belong to the same caste/community as the samples revealed in earlier cases.

The investigator found that in both the cases of mentally retarded children's and normal children's families the number of families having expectations mildly fulfilled is highest whereas completely fulfilled expectations were found to be higher in case of normal children's family and frustrated were higher in case of families of retardates. The result of examining the variations of education, income and occupation for finding out the issue of fulfilment of expectations of the partners of parents of mentally retarded children show that low income group of parents in occupation of business and having higher educational level have borne maximum feeling of frustration and mildly fulfilled sense of expectations. The line of the results is that people with lower income and having absolute tradition-occupation but having some education find a contradiction between their ideas and realities. This obviously might be resulting in their not having a sense of satisfaction from their spouses, who are the closest individuals in the family.

Hence the family of retardates show the tendency of frustration in the matter of expectations fulfilled amongst the partners. Elliot and Merrill remarks, "Men and women are demanding greater personal satisfaction from the state of matrimony. But then one has to work harder at making marriage a success. Also greater emphasis upon personal happiness in marriage deserves analysis as to its essential validity. Life exerts difficulties as well as pleasures and is full of petty annoyances, disappointments and disillusionments both in and out of marriage. Probably no married people were completely happy before marriage, nor can they expect to be completely happy after marriage. Many youngmen nourished in the romantic tradition may blame their marriage if they feel unhappy whereas the difficulty may lie either within themselves or in situations external to marriage."[10]

Conclusion

Even though relatively few people find the perfect happiness they assume that marriage had in store for them, many husbands and wives muddled through their domestic problems. They recognize that marriage has much to offer in companionship, sympathetic understanding and conjugal affection. They eventually realize that the romantic raptures of motion pictures do not exist in everyday life and the calm and pleasant companionship, the dependence of husband and wife in the petty details of their daily life, and similarity of basic values—these are the factors which contribute to happiness of family life. Majority of men and women thus, make fairly satisfactory adjustments, whether from force of habit, social pressure or inescapable destiny.

For some couples, however, life does not go on smoothly owing to various reasons discussed in this chapter. This tends to interrupt the process of living together, creating tensions in the lives of partners.

In the present work it has been found that most of the mentally retarded children belong to joint families, and these joint families produce a very gloomy picture. Because unity of interests in almost all respects is mostly possible in an agricultural joint family, where in matters of religious practice, education, recreation and economic activities the various members participate as an unit. Such an identification is difficult in modern urban

life, where members of the family develop different interests by virtue of their roles in various secondary groups. The findings indicate that the ralationships of the members of these joint families are often marred by bickerings or tensions but they are still continuing to function on a fairly acceptable plane.

The information collected from house to house reveals that these joint families are unhappy and replete with tension of all kinds. The tension in the family are mostly due to economic and occupational situations, cultural differences, differences in social status, matters of ill health and interference of in-laws.

In the families of subject group the expectations of parents from their partners are mostly frustrated and mildly frustrated as compared to the expectations of the parents of comparison group from their partners. The romantic expectations of the partners with which they entered marriage were frustrated by the un-romantic realities of the marital situation.

The marital adjustment between the parents is of profound significance in determining the attitudes of the children and for their mental and social development. The psycho-social influence of the family environment on the child is so deep and so quick that in the view of the psychologists the child acquires almost all its personality and character traits of later adulthood before five, and according to some others, even earlier. The family also provides for the satisfaction of the four fundamental wishes or desires, viz. the wish for new experience for security, for recognition and for response. The new experiences, the new stimuli, the new associations the child meets within the family environment aid in its mental and social development. The satisfaction of the need for security begins with the physical and emotional security, given to it from birth onwards by embracing, caressing, nursing and other kinds of personal attention. The need for recognition is satisfied through the roles the child plays in the family, the attention he secures, the status he occupies, the approvals he gets therein. The need for response is satisfied through the affection and the comradeship he receives in the family. So a proper and healthy marital adjustment plays a very important role for the mental and social development of the child.

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5

Parent-Child Relationship

The relationship of the retarded child with his parents is more important than the relationship of the intellectually normal child with his parents. His personality including his emotional stability or instability is to a considerable extent a reflection of the personalities and stability of his parents.

The parents of a retarded child are in a different situation. Because of the attitude of the society they may feel ashamed of their offspring and the feeling of shame may result in overt or covert rejection. Many families drastically alter their way of life because of the presence of a mentally deficient child in the family circle and withdraw from community activities almost completely. In such a situation, the retarded child is likely to have a vague and uneasy realization that he is to be blamed for this. Of course, not all the parents respond negatively to the presence of a retarded child in the family circle.

Freud believes that the first five years have a very important place in the life of a man. But these five years shall not be considered only according to the chronological age but also mental age is to be considered. If a child develops under the guidance of superior parents usually he will have a better chance of developing a good intelligence.

The process of bringing up a child is rarely entirely pleasant. Patience, understanding, ingenuity and strength are required in large measures from the parents of even a bright and healthy youngster. Whatever their temporary anger, guilt, disappointment or deprivation, the parents of normal children can usually maintain an atmosphere of confidence and acceptance, sustained by the reasonable assurance that everything will turn out all right.

For the family of a retarded child, the situation is more complicated and more hazardous. The particular handicaps of the child, the slowness of his development, the necessity of special arrangements for his physical care, training and companionship and the adjustments which must be made in the family's expectations for the future, combine to create pressure on the parents which tends to disrupt the normal family equilibrium. Added to this pressure may be tensions created by the child's difficulties in interpersonal relationships, his slowness to learn, his immature self-control and his handicap in communication. At the same time, the parent-child relationship is intensified by the child's prolonged immaturity and isolation from a peer group. In some instances, the child remains emotionally and economically dependent upon his family throughout his life.

Thus, the relationship between a retarded child and his family is not only more complex and ambivalent than the ordinary one, but also more intense and prolonged.

The family is connected with the satisfaction of all the needs of the child from the most material needs such as food and drink to the most spiritual such as security and affection. The dependence of the child upon the family for the satisfaction of his needs is most complete at birth and gradually diminishes with varying rates of speed in different societies until a certain minimum is reached.

Kingsley Davis observes, "The family furnishes both kinds of relationship—the authoritarian (as between parent and child) and the equalitarian (as between siblings)—within which socialization can take place. Each type of relationship supplies a unique and necessary element in socialization."[1]

"The families least able to contend with difficulties, those in which the parents are themselves dim witted, ineffectual or neglecting and who often produce large numbers of children are the ones least able to cope with the training of children of low intelligence. Hence the duller offspring from such families are very liable to be ascertained subnormal, thus perpetuating from one generation to the next a complex of social problems that is likely to include both subnormality and delinquency."[2]

Uninterested and neglected parents, who are often dull themselves, give their offspring insufficient stimulation. They do not

bother to talk to them or to explain things; they do not give that loving encouragement which is an essential part of training and as a result their children never learn to take things properly. "Extreme examples are on record of unwanted children, usually illegitimate, shut away in solitude in an attic. Such children, if they pass the critical age when social contacts and languages are normally learnt, may remain permanently imbecile. In less extreme cases, transfer to a good foster home, provided it takes place while mental growth is still possible, results in a considerable increase in test-score."[3]

Clarke and Clarke[4] studied the changes in intelligence quotient among subnormals which took place over a period of eighteen months following committal to an institution. The prospects of improvement with training were better with those from the worst homes, presumably because in their case environmental factors predominated. The subnormal children who came from very adverse backgrounds made an average increase of ten points of IQ compared with an increase of only four points in those from less bad homes.

A wide variety of adjectives have been used to designate aspects of the parent-child relationship. Families have been characterized as autocratic, arbitrary, rejecting, neurotic, overprotective, neglectful, democratic, rewarding, possessive, accepting, detached, harmonic and so on. A number of studies have demonstrated that psychological characteristics in children tend to be related to certain general kinds of parental relationship with their offsprings. Psychologists of Fields Research Institute, for example, have established a relationship between ratings of parents behaviour and of their children's behaviour in nursery school. Children from homes rated as 'democratic' were more active, socially outgoing, intellectually curious, creative and constructive; children from 'indulgent' homes were by contrast more physically apprehensive and less skilled in both large and small activities.[5]

So it can be said that in countless interactions each day, the parents communicate to the child their interpretation of the world and the way in which they expect him to behave in it. They teach him what to like and what to despise, whom to obey and against whom to rebel, and when to strive actively against circumstances and when to submit to the inevitable.

The Temperamental Attitudes of Parents of Normal and Retarded Children

We have studied only a few variables of child-parent relationship mainly concerning the emotional support of the child.

The personality temperament of father and mother are crucially related with the problem of child-parent relationship. The temperamental variable is studied in relation to maintenance and enforcement of discipline in the child. It seems that unwantedness by the parents and unsympathetic and unimaginative enforcement of discipline are meaningfully related with the phenomenon of mental retardation. Case histories are given to illustrate the variables.

General temperaments of the parents of the retarded and normal children were investigated. Both in the cases of normal as well as retarded children, it was found that the father is generally more of a disciplinarian than the mother. In the case of disciplinarian attitude of parents, investigations revealed the results as shown in the following Tables.

TABLE 35

Temperamental attitude towards enforcement of discipline by the parents of normal children

Parents	*Number of respondents*	*Percentage*
Fathers	48	64
Mothers	15	20
Both	12	16
Total	75	100

Strictness in enforcement of discipline does not seem to be so important as the nature of emotional support given to the child. The mother and the father of normal group children are often found to be as strict as the parents of retarded children. Of

course, the number of strict fathers is more in the retarded group. Otherwise there is no significant difference. In Indian middle-class families, the parents are generally eager to enforce discipline in their children. They may develop other minor behavioural troubles in children because of strict enforcement of discipline but it would not lead to mental retardation. But strictness combined with unwantedness seems to be more meaningfully related with mental retardation as is evident from the case histories Nos. 6 and 7 given in Chapter 8 of this book.

TABLE 36

Temperamental attitude towards enforcement of discipline by the parents of retarded children

Parents	*Number of respondents*	*Percentage*
Fathers	55	73.33
Mothers	12	16.00
Both	8	10.67
Total	75	100.00

Unwantedness, Rejection and Mental Retardation

Investigations revealed that unwantedness and rejection both were meaningfully related with the mental retardation of the child. Unwantedness and rejection of a child may sometimes be openly shown by parents but more often it is disguised. The child may be replaced in an institution or in a reformatory or a boarding school not because circumstances demand it but because the parents do not want to be bothered by the responsibility of bringing up the child. Unnecessary and unfavourable comparisons with siblings or neighbour's children is another indication of rejection. Rejection and neglect of the child is also seen in cases where the mother was very adverse to pregnancy at the particular time, actually contraception or abortion might have been attempted. Case history No. 2 which has been discussed by the

investigator in Chapter 8 is one such example of an unwanted child. Also case histories No. 6 and 7 reflect the correlation between unwantedness and mental retardation.

There may be also rejection by the parents because the child is a step-child or an adopted or illegitimate child.

In 1951, Dr John Bowlby issued a report on "Maternal Care and Mental Health". He writes, what is believed to be essential for mental health is that the "infant and the young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother—substitute one person in which both find satisfaction and enjoyment). It is this complex, rich and rewarding relationship with the mother in early years varied in countless ways by relations with the father and with the brothers and sisters that child psychiatrists and many others now believe to underline the development of character and of mental health."[6]

In this investigation it was revealed that of the total samples collected for the study, 73.33% of the retarded children were unwanted for their parents whereas in case of normal children only 2.67% were of such type. The findings are placed below and compared with the parental attitude of normal children.

TABLE 37

Attitude wanted and unwantedness of the parents of retarded and normal children—comparative data

Parents of children	*Wanted*	*Unwanted*	*Total*
Retarded	20 (26.67%)	55 (73.33%)	75 (100.00%)
Normal	73 (97.33%)	2 (2.67%)	75 (100.00%)

The figures revealed that normal children experience the feelings of being wanted, loved, protected and are affectionately brought up. The parents of normal children (97.33%) express the feelings of wantedness in comparison to the parents of mentally

retarded children (26.67%). The experience of unwantedness is negligible (2.67%) in normal children whereas it is more (73.33%) in the retarded children. The phenomenon of unwantedness has the following causal factors:

(a) Attempt of abortion.
(b) Unpreparedness for the parenthood.
(c) Scolding and beating on slight provocations.
(d) Leaving the child for long period in the hands of further unwanted persons like maid servants and nagging kins.
(e) Neglect of subsistence needs.
(f) Administration of drugs for keeping the child asleep in the nights, etc.

In free discussions with the parents of the mentally retarded children it has been found that many of them are emotionally immature persons. They have got the issue early after their married life. They have regarded the child as a hindrance in a pleasure-seeking conjugal life. Some of them have untrained maid servants who have treated the children with indifference. The total impact of unwantedness results in a severe sense of helplessness and non-adaptive behaviour in the children.

Attitude for Punishing the Child

Mentally retarded children have always given an appearance of being vulnerable to emotional problems because of their intellectual handicaps. Their deficiencies in judgement, in understanding the environment and their anticipation often leads them to failure. Because of their failure to behave according to accepted norms, they have a feeling of isolation and they become closely tied with their families. Normally the families also fail to fulfil the expectations of the mentally retarded child and the child often feels rejection and strong ambivalence in the attitude of his parents or siblings. In many cases the natural failures of the child are also regarded by the parents or the siblings as an expression of retardation which is commonly termed as foolishness by the members of the family, and sometimes the child is even penalised. In consequence the child's physical needs and psychological requirements for security and warmth are met with an unsympathetic attitude often culminating in punishments of all kinds.

On investigating the issue of attitude of parents in punishing the child it was found that in the case of mentally retarded children 58.67% were positively admitting doing so often and 20% admitted doing so sometimes, and only 21.33% denied resorting to punishments. In case of normal children 69.33% have been found not to be in favour of punishing the child. The results have been tabled as under.

TABLE 38

Comparative data showing the attitude of parents for punishing their children

Parents of children	*Yes*	*No*	*Rarely*	*Total*
Retarded	44 (58.67%)	16 (21.33%)	15 (20.00%)	75 (100.00%)
Normal	20 (26.67%)	52 (69.33%)	3 (4.00%)	75 (100.00%)

The investigation thus shows that admitting positively and also admitting sometimes for punishing the children about 80% of the parents of mentally retarded children are in favour of punishing the child.

"A child's history of success or failure affects his level of aspiration, self-confidence and degree of realism in the goals he sets."[7] Obviously when a child fails to achieve fulfilment of expectations he gives up his efforts. So, in imparting punishment to the child or when punitive action is taken, the child is rendered to feel more helpless. The parents from the subject group of study of retarded children have confirmed the analysis of their being punitive in their attitude towards the failings of such children. Even those who have admitted to punish rarely have been found to be in favour of such punishment.

Behaviour of the Parents towards their Children

Parents of retarded children feel somewhat isolated from the society for having offsprings who are hardly given social

recognition. The father of the retarded child has lesser to do than the mother. The mother actually is often exposed to the notion of being the protector and saviour of the child and she sometimes feels like blaming herself and this often has given rise to the expression of 'over-protection from mothers' side'. The father on the other hand, though, generally not in favour of beating the child, often discards the child by snubbing, as he feels, he has many other problems to tackle with. In our country which is mainly composed of patriarchal type of families the man mainly has the responsibility of feeding and rearing up the children and has not so much time to be worried about the child as the mother. Obviously he has a limited behaviour for the child. He can be found active in matters of scolding, beating, showing tolerance, granting excessive freedom or being totally apathetic to such children. Mothers are more given to being over protective for the child or being balanced in it. There is hardly any mother who is apathetic towards her child.

In this study the behaviour of parents have been discussed separately for both the subject groups of retarded children and for the group of normal children.

Behaviour of Father towards the Child

Behaviour of fathers towards their normal and retarded children has been examined by asking them few questions mentioned in the Tables. The results obtained are tabulated below.

TABLE 39

Behaviour of fathers towards the retarded children

Reaction of behaviour	*Yes*	*No*	*Sometimes*	*Total*
Scolding	56	9	10	75
Beating	11	44	20	75
Tolerating	27	47	1	75
Over-protection	14	61	—	75
Frustrated	17	58	—	75
Fulfilling all desires	10	50	15	75
Granting excessive freedom	8	63	4	75
Apathetic	12	57	6	75

TABLE 40

Behaviour of the fathers towards normal children

Behaviour	*Yes*	*No*	*Sometimes*	*Total*
Scolding	15	60	—	75
Beating	21	48	6	75
Tolerating	9	66	—	75
Over-protection	8	67	—	75
Frustrated	3	72	—	75
Fulfilling all desires	16	59	—	75
Granting excessive freedom	9	66	—	75
Apathetic	—	75	—	75

In case of 75 families that have been examined 56 fathers of mentally retarded children are in favour of scolding them often and 10 in favour of scolding sometimes, but this attitude is not so in the matter of beating or otherwise punishing the child. Of course, mentally retarded children have been found to be tolerated by their fathers and some have taken an apathetic attitude towards them whereas in the case of normal children there has been no apathetic attitude and there are lesser scoldings.

Behaviour of Mothers towards their Children

The mother's attitude towards her child has been found generally of over-protection for the retarded child than in case of the normal child. Of course, mothers are not at all apathetic to their children in both the cases of normal as well as retarded children. Behaviour of mother analyzed for both the groups of children can be tabled as shown on the next page.

The Table reveals that there are many mothers of retarded children, i.e., (56 out of 75 families) who by over-protection damage their children. There are many retarded children in this study who have failed twice or thrice in a class due to over-protection of their mothers (as admitted by the mothers of such children).

TABLE 41

Behaviour of mothers towards their children

Families	*Over protection*	*Excessive freedom*	*Apathetic*	*Balanced*	*Total*
Retarded	56 (74.66%)	4 (5.34%)	—	15 (20%)	75 (100%)
Normal	10 (13.34%)	5 (6.66%)	—	60 (80%)	75 (100%)

Conclusion

According to the science of human behaviour most of the family conditions leading to mental retardation is fragmentary, speculative and difficult to interpret. Still it seems abundantly clear that some circumstances are more favourable than others; that while most of the children grow up in situations which are on the whole conducive to their intellectual growth, others live in situations which retard or stop development in this sphere. As we have seen that the children from low socio-economic classes, and the unwanted children consistently score lower on intelligence tests than the children from higher groups.

The comparative data that have been collected for this study showing child-parent relationship can be concluded as follows:

(1) The unwanted or disliked child in the family setting may be rejected in numerous ways. An unstable or indifferent mother, a mother who is overburdened with the care of many children or a mother who is antagonistic towards her baby or her role as mother, may provide minimal physical care with little sign of personal warmth or an environment in which there is variety, stimulation and responsiveness. Other expressions of rejection which tend to be more active are reflected in hostility in the emotional atmosphere and in mishandling rather than in ignoring the child. Apparently, these situations tend to produce symptoms which are

expressed primarily by tension and only secondarily by intellectual conflict. The evidence indicates, however, that without adequate stimulation both the emotional and intellectual development of the child may be retarded. Parental attitude and the home atmosphere have also received a great deal of attention by the investigator. For example, in some cases a mother may make a pathetic figure struggling to cope with her own shortcomings. Married to an inadequate, aloof man, she hopes to find her true fulfilment as a mother. When she realizes that her dreams are not coming true, she struggles to control the child, and he, in turn, survives only by retreating from her. There are several studies which reveal that early maternal deprivations have severe emotional and intellectual consequences on the child. In a recent careful review of the literature, Casler (1961) concludes that "infants losing their mother after six months and before three years may have long-term ill-effects, but those who lose them earlier or later do not."[8] More recent research suggests that perceptual, social and other forms of stimulation are very important for the normal development of a child.

In some of the cases of mentally retarded children the social workers of the institution (from where the samples of subject group were collected) were of the opinion that the cause of mental retardation is the negligence and ill treatment of the parents of the retarded children.

(2) As the study reveals, most of the parents of the mentally retarded children have the attitude of punishing the child. But it is more harmful and dangerous because it can further retard the mental growth of the child. As an infant begins to move under his own power to manipulate things and to throw things he is likely to get in the way of adults who are already likely to be ill-tempered from their own discomforts and frustrations. In such an atmosphere a child's opportunity to carry out the activities required for his locomotor and manipulative development must almost inevitably be sharply curbed. Moreover, late in his life, after he has developed a number of *pseudo* (unreal) words and has come to know that these words have meanings, the children in crowded poverty stricken families meet other obstacles. Their questions rarely bring suitable answers; mostly they bring punishment or negligence that inhibit further questioning. Generally hostile and discouraging environments affect seriously the later life of the retarded.

(3) The parents of a mentally retarded child go through some kind of a developmental sequences in reaching a full acceptance of their particular identities as parents of a retarded child. In the time taken by the parents to feel that their child is retarded, *they behave in three phases.* Phase one—when the chief orientation is that of self-pity, guilt and resentment; phase two—when the interest becomes focussed on finding ways of helping the retarded child to develop; and phase three—when interest is expanded to joining with other parents in seeking to help all handicapped children. Most of the parents behave emotionally, and being disturbed, aggressive, hostile or bossy they cannot pay proper attention towards their children.

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6

Behavioural Interaction

In this chapter the behavioural interaction of the mentally retarded child (N) has been described in relation to the members of the family other than parents. The relational narrower circle includes siblings, grand-parents and other elder members. The purpose of this investigation is to find out the supportive or rejective response of these family members to the unusual behaviour of the retarded child. It is needless to emphasize that members of the family exert detrimental influence on the development of personality of younger members. But in case of a retarded child these relations become more decisive.

The individual and the family are closely related. Although the individual is endowed with certain biological and mental capacities and potentialities at birth, he soon becomes a social animal. While studying a person, we have to study his various mental, physical and temperamental characteristics, which often offer a significant clue to the behaviour of the person and the understanding of his role in the various groups of which he is a member. Professor Burgess points out, "An adequate study of the person must include the nature and extent of his participation in the manifold groups of which he is a member, his personal behaviour pattern, his philosophy of life, his life organization"[1]. The individual's very self, his personality, his human nature, are all social products, derived from his complex interaction with the social groups which make up his expanding environment.

For a retarded child his whole social milieu is confined to his family. His need for response is satisfied through the affection and the comradeship he receives in the family. The psycho-social influence of the family members on the child is very deep. There is an

obvious reciprocal relationship between a retarded child and his family. The more favourable the relationship, the more stable, traceable and self-possessed the child will be, and the greater will be the happiness and stability of those who live with him. In turn, he will be more likely to gain the affection and support the needs to enhance his healthy adjustment. Such, in essence, was the finding in an extensive survey by Saenger (1957)[2], who followed up retarded adults with IQs below 50 as children had attended special classes in New York City. He discovered that presence or absence of personality problems in these retarded adults showed an exceedingly high relationship to the extent of parental acceptance, family cohesion and degree of overprotection, as measured in an index of family relations. Of the cases from families whose relationships were characterized as satisfactory, only one-fourth of the parents reported that their retarded children presented serious problems of adjustment such as stubbornness and over-dependence. In contrast, of the families in which tension and rejection of the retarded child were marked, more than three-fourth of the retarded children were reported as presenting adjustment problems. Saenger found that acceptance or rejection of the retarded adults was related primarily to the general emotional adjustment of their parents and to their ethnic group.

The Retarded Child and the Routine of the Family Life

Normally such a handicapped child is a problem to the family in matters of discipline and maintenance of cohesive family life and it often creates repercussions within the family. They are given expression to the members of the family in petty things as refusal to carry out orders, by going astray, sometimes they also become violent with other children. All these are the various problems put forward by the other members of the family. To know their feelings better some precise questions were asked. For concise statistical figures the questions are put under the following heads:

(a) Refusal to obey for constructive work,

(b) Going astray,

(c) Creating behavioural disorder with household things,

TABLE 42

Behaviour of the retarded children upsetting the family life

Nature of behaviour disorder	*Number of retarded children*	*Percentage*
a	32	42.6
b	9	12.0
c	34	45.4
Total	75	100.00

The above table indicates that generally the main complaint by the members of the family against the ratarded child involves disturbances in the family by behavioural disorders like disturbing and destroying things and by showing disrespectful attitudes created probably by their lower level of intelligence and understanding, or otherwise behaving in an unbefitting manner. Such disorders in behaviour especially with household things cause repercussions in family life and they are highest in the samples analysed: 45.4% positively suggested such disorders to be the reason for upsetting the routine of the family life.

About 42.6% felt that such children are unable to follow the instructions and are unable to do constructive work. Obviously for reasons of their being handicapped in their mental accumen for such pursuits (expected from and judged by the standard of a normal child) only 12% have said that such children go astray.

Behaviour of the Mentally Retarded Child with his Siblings

Robinson says that 'the presence of a retarded child adversely affects the development and happiness of his siblings.'[3] Most frequently these situations develop when the retarded siblings claim so much of the parents attention that there is not enough left for other children. Very frequently, however, it is not the realistic demands made by the retarded child, but the irrational

elements in the parents behaviour towards them which work the hardship on the non-handicapped children.

In B. Farber's[4] studies, no control groups were utilized but he gathered interesting data about the siblings of severely retarded children. He thought that for a number of reasons, the effect of a retarded child on his siblings should be different from that on his parents. Farber conceived of the family as consisting of a number of three-person relationships (triads) each composed of the parents and one child. Each family would contain as many triads as there were children, the centre of organization, thus, residing primarily in the parents. The effect of the retarded child under such conditions would be felt by the siblings primarily as it was transmitted to them by the parents. The brothers and sisters would be less deeply affected by the arrest in the family's lifecycle, which is relevant to parental behaviour and more deeply affected by short-term immediate situational factors. His research data tended to substantiate these ideas.

In contrast to his findings concerning the marital integration of the parents, Farber discovered that the sex of the retarded child and the social status of the family made little difference in the adjustment of the normal siblings. The variable which seemed of greatest importance to the siblings was the degree of dependence of the retarded child, i.e., how much he was able or permitted to do for himself. The more dependent the child, compared with other retarded children of his age and the younger (also more dependent) he was, the more adverse was his effect on his siblings.

TABLE 43

Retarded children's behaviour orientation to their youngers

Behaviour orientation	*Number of children*	*Percentage*
Orientation of love	58	77.33
Shows no love	17	22.67
Total	75	100.00

For this study the parents were asked to comment about retarded child's love and affection for his siblings. It was noted that the particular child was affectionate and love oriented towards them as evident from the above Table. Love orientation was noticed among 77.33% and those who do not express love for their siblings were 22.67%. It shows the effect influence of typical Indian family socialisation pattern on the retarded child. Because of his mental retardation the retarded child is not a valued member of the family. He is not encouraged to express hostility towards his siblings. Moreover, he is dependent in play and other necessities of life on his normal siblings. These factors might condition him to a genuine or assumed behaviour of love and sympathy. Those who cannot check their hostility express open hostility or cold behaviour to their siblings. Their number is not insignificant and they show a major trend, an important trend, in sibling orientation. A hostile behaviour of mentally retarded child is a source of constant anxiety in the members of the family.

TABLE 44

Retarded children's attitude to elders

Retarded children	*Number*	*Percentage*
Have fear for elders	52	69.33
Have no fear for elders	23	30.67
Total	75	100.00

Elders of the family are usually very much critical and conscious of the behaviour of the retarded child. About 59% of the parents were found inflicting severe punishment and about 20% rarely punished their children for the lapses in behaviour of the retarded child (Table 38). The retarded child may have the impression of being less wanted and consciously observed, and that is why authority of the elders is repressive for 69.33%. Only 30.67% were not so much afraid of the authority of the elders. Though fearful regard for the elders is a traditional behaviour

pattern of the younger members in an Indian family, but such a large number of retarded children being afraid of their elders, is a significant phenomenon. It can be fairly concluded that retarded children have no normal rapport with the elders. This might be responsible for further deterioration in their adjustive behaviour.

TABLE 45

Retarded children *vis-a-vis* younger members of the family in terms of quarrelling

Frequency of quarrelling	*Number of retarded children*	*Percentage*
Frequently	23	30.66
Occasionally	38	50.67
Rarely	14	18.67

As evident from the above Table the parents noticed that their retarded children were usually not properly adjusted in sibling relations. It was reported that 30.66% resort to quarrelling very frequently and 50.67% quarrel occasionally. Only 18.67% were quiet retarded children. These figures indicate an adjustive behaviour trend of the retarded children under study. So, the data reveals that the majority of the retarded children are neither severely quarrelsome nor severely hostile but the majority of them are in constant state of fear of their elders. Fear might be an associative factor in the non-adjustive behaviour pattern of retarded children.

Negative behaviour of mentally retarded children towards their siblings and vice versa

A certain distance between normal sibs and the retardates and disinterestedness on the part of the latter is a very important phenomena of family life of mentally retarded children. In this study it was found that most of the children showed no inclination to

rejection both from the side of the siblings and from the side of the mentally retarded children. But in the matter of sharing of play things the mentally retarded children have shown a negative attitude. Obviously because a retarded child is undeveloped in mental age compared to his chronological age he behaves like a boy of smaller chronological age of normal group and in the matter of play things such children display more possessiveness and are not ready to part with or share with other children. Otherwise the mentally retarded children in this study in majority were not even found to be jealous of other children. The following Table reveals the abovementioned information.

TABLE 46

Retarded children's withdrawal from the siblings

Tendency	*Number of retarded children*	*Percentage*
To withdraw	18	24
Not to withdraw	57	76
Total	75	100

The above Table shows that only 24% of the mentally retarded children want to keep themselves isolated and do not like the association of other siblings, whereas 76% are quite inclined to associations with their siblings. It is quite possible that in cases of the children of this group, who were not found to be favourably inclined to associations, the behaviour might have been due to the result of the attitude of their families. Continually treated as subnormal and faced with constant threat of rejection such children may have developed moroseness in themselves and a kind of fear of the company of other children or siblings.

In cases of other siblings it was found that majority was not in favour of keeping association with their mentally retarded brother or sister. The result analysed shows that 54.67% were

rarely inclined to be friendly with such children, and 5.33% were occasionally found to be friendly and only 40% replied positively for such an inclination. It is quite possible that the normal siblings of the family feel a sort of superiority complex and hence keep themselves aloof from such retarded children and they have little flow of fraternal love for such handicapped members of their families.

TABLE 47

Rejection of retarded children by the normal siblings

Rejecting attitude	*Number of retarded children rejected*	*Percentage*
Frequently	41	54.67
Occasionally	4	5.33
Rarely	30	40.00
Total	75	100.00

TABLE 48

The retarded children's attitude of sharing play materials with normal siblings

Attitude of sharing play materials	*Number of retarded children*	*Percentage*
Frequently shares	27	36.00
Rarely shares	44	58.67
Occasionally shares	4	5.33
Total	75	100.00

Majority of the retarded children, i.e., 58.67% were rarely in favour of sharing the play materials with their siblings.

As revealed earlier, it was found that majority of normal children were not in favour of keeping association with the handicapped child. It may be that as a result of a reciprocal introvertive moroseness that these children feel, for reasons of expressions superiority by other siblings, they create their own world and they are not favourably inclined to share their play things. This temperamental seclusion created in such handicapped children makes them isolated mentally and they have their own way of satisfying their whims of isolation. They seem to be hardly willing to share their world with other siblings and in case of such other children trying to come into their world they seek to secure a way by refusing even to share their own play things. It is a typical chain of isolation created by both ends—one by rejection and other by feeling of insolation.

Behaviour of Other Family Members towards the Mentally Retarded Child

In the present work it was found that majority of mentally retarded children belong to joint families which necessitates the study of the behaviour of other members of joint families towards the retarded child.

In nuclear families it is the parents or the siblings who have the only role to play for the growth and social behaviour of the child but in joint families other members like grandmother, grandfather, uncle, aunt, all have important roles to play and their behaviour also may be a source of study for drawing a conclusion about family behaviour towards the child.

The Table below gives the data regarding the mode of behaviour of such famliy members *vis-a-vis* the mentally retarded children.

The above findings reveal that 28% of members of the families of retarded children were apathetic towards their children and 14.6% took punitive attitude, whereas the behaviour of 34.7% was protective towards the retarded children; 22.7% were found indulging in retarded children's affairs. It might lead to either over perfectiveness or aggressiveness and punitiveness.

TABLE 49

Behaviour of members of the family towards the mentally retarded children

Behaviour of the members of the family	*Number of mentally retarded children*	*Percentage*
Protective	26	34.70
Apathetic	21	28.00
Indulgent behaviour	17	22.70
Punitive	11	14.60
Total	75	100.00

Conclusion

In this chapter, the interaction of the retarded child with members of the family other than parents and vice versa was empirically described. Certain aspects of family interaction, very common in nature, were taken as indicators of the mode of interaction. The purpose was to find out how far the retarded child is integrated with others and how others are supportive or rejective of his behaviour. This could have brought to the notice the severe rejective or protective patterns of behaviour toward the retarded child. Also the retarded child being mentally retarded might not be normal in interaction with the siblings and other members. But nothing particular, indicating serious breakdown in family interaction pattern, was traced on the basis of data available. It might be due to the fact that the retarded child enjoys the rightful status of the family member. The senior members were more protective than punitive.

The siblings of the retarded child have shown a little higher tendency of rejecting the retarded child in play. There is nothing unusual in for normal children not associating with this child who might be non-cooperative in playing or sometimes destructive.

This rejection seems to be situational concerning children's play but on the whole the siblings also have normal affectionate behaviour interaction with the retarded child. The latter is valued by his or her sibling as a valued member of the family. On the basis of data we can confirm only this much that the retarded child is not severely rejected by the siblings and members other than the parents.

The unfortunate retarded child, is somewhat a misfortune for the family as well. This fact is accepted and dealt within the family in an usual way. But it is also a fact that the child does receive extraordinary love or affectionate response from the members of the family.

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7

Factors of Mental Retardation as perceived by the Parents and Clinical Care availed by them

Every family of a retarded child must at some time face the fact that the child is mentally handicapped. The circumstances of this recognition may be sudden or gradual, the realization may come at birth or be avoided until the child has been in school for several years. Parents of a retarded child often need help in dealing with their family situation in recognizing and accepting the child's handicaps and in handling certain day-to-day problems of living with both this child and his normal brothers and sisters.

Most parents develop an understanding of their child's condition in a gradual and painful manner. Many spend a great deal of time, energy and money in a desperate search for some more acceptable diagnosis or for an elusive cure. The process of acceptance seems to follow a rather regular pattern, whether it covers a period of years or is telescoped into a single interview. Parents who have more or less accepted their child's retardation apparently pass through about five successive stages in the process (Rosen, 1955). "The first stage is characterized by an awareness that a serious problem exists; the second by recognition of the retardation for what it is; the third by a search for the cause; the fourth by a search for the solution; and the fifth, by acceptance of the problem a goal which is seldom fully attained."[1] Rheingold (1945)[2] has described much the same sequence in successful interpretive interviews with the parents. So the parents perceive their child's mental subnormality with a profound sense

of shock. Their dreams of the future shattered, their own feelings of adequacy seriously shaken, and many of them experience a grief reaction during which, for a time, they withdraw from others in pre-occupation with their own sorrow. Most parents need time to adjust themselves.

As soon as the parents become aware with the fact that their child is mentally retarded, competent medical and psychological examinations should be carried out. Parents whose children are damaged but who have not been given professional aid in understanding their condition are beset by worry, self-blame and anxiety; the entire parent-child relationship is likely to be disturbed while the parents assume the burden as though it were entirely their fault that all is not well (Prechtl 1963).[3] "Once they face the issue, moreover, parents can be very accurate judges of their children's level of development" (Ewert and Green 1957; Schulman and Stern, 1959).[4] At this stage, the psychologist can be of help by listening sympathetically and helping the parents to interpret their observations, using the results of psychological testing and observation only to confirm their judgement.

On confirmation of the diagnosis, it is essential to institute immediately vigorous treatment. Early diagnosis followed by long-term parental counselling and guidance by the physician or appropriate para-medical or educational specialists is very much needed. Drugs play an important role in the psychiatric treatment of the mentally retarded.

The end of the 19th and the early part of the 20th century witnessed a gradual withdrawal of the interest in the problem of mental retardation on the part of physicians. It was left to the psychologists and educators to pick up the slack and to make the major contributions to the understanding and the management of mental retardation. This phenomenon was more pronounced in the United States than in Europe.

Improvement of prenatal care is a must to prevent mental retardation. To begin with, restricting the number of pregnancies in adolescence and after the age of 40 reduces the risk of chromosomal aberrations. Pediatric prevention measures cover acute and long range problems.

IQ Level of the Mentally Retarded Children

The information concerning the IQ of the mentally retarded children obtained in the present study has been shown in the following Table.

TABLE 50

IQ level of the mentally retarded children

Degree of IQ	*Number of retarded children*	*Percentage*
20-35	13	17.33
36-51	40	53.33
52-67	22	29.34
Total	75	100.00

As the Table indicates, most of the mentally retarded children have an IQ range between 36-51, that is, out of 75 retarded children 40 children are in the moderate IQ group. These children can usually talk coherently in short sentences, sing little songs, and partially dress themselves in about the same manner as 4 or 5 year old normal children do. They fight with their playmates over sharing toys and they have relatively brief attention span unless they are vitally interested in a particular activity and cannot read or write. Nursery school experience in the company of other retarded children might well be profitable and enjoyable for them.

Out of 75 retarded children, the next major group of 22 children fall in the IQ range of 52 to 67, that is, they are mildly retarded. They are likely to be capable of maintaining themselves. Even with special education these children have completed only fourth or fifth grade work. They can probably learn to read, understand simple games with definite rules and make their ideas understood. In their social relationships they have close friendships with others. Some of the boys in this group can ride through

the neighbourhood on their bicycle for their group play, etc. Of the sample 17.33% children, i.e., only 13 children out of total number of 75 retarded children have the IQ range between 20 to 35, i.e., they are severely retarded, they have the mental age of about 4 to 6 years and they show some neurologic damage also which, to a great extent, affects their social behaviour. These children are very much helpless. They need special training in learning to talk and care for their own simple cleanliness and health needs. No academic training for children is effective. Social worker informs the investigator that these children have damaged central nervous system to a great extent.

Causative Factors of Mental Retardation in the View of Parents

Once the parents recognise the extent to which their child is retarded, most of the parents next seek the cause of the tragedy which has beset them. But no one knows, or has been able to find out precisely the reasons why some of these children are retarded. Only in a very small number of cases, after study, doctors are able to say why a particular child is retarded. They suspect many diseases or mishaps of having a part in causing retardation.

Different factors concerning mental retardation have been discussed in the introductory chapter of the present work. Only such factors of retardation are discussed here which, according to the parents of the present samples, are responsible for bringing about the mental retardation of their children.

Most of the parents generally stuck to supernatural factors as *Karma* or God as the cause for retardation of their children. Of course, they generally harbour an ardent desire for granting relief to their children and for that they have a motive for searching and removing the causes of retardation of their children. In other cases parents suspect some biological reasons as the cause which, though not being precise, indicates a sense of responsibility and guilt in the parents.

In most instances, identifying the precise cause would make little difference to the child. Whatever physical damage has occurred is largely irreversible. Evaluations of the child's current status and of any factors which continue to contribute to his

handicap can, on the other hand, be of great value for parent counselling and for planning, treatment, training or placement.

After competent medical and psychological evaluations, parents who cannot be given a definitive etiologic statement do, however, deserve recognitions of their feelings of responsibility and guilt. Even the extremely rare parent who has damaged a baby through a wilful act, such as an attempted abortion or a traumatic beating, can be accorded understanding and compassionate acceptance. Most of the parents find some relief from guilt when they learn of the great number of families who share their problems, the multiplicity of factors which can interfere with the delicate balance of normal development, and of the overwhelming likelihood that their child was damaged before birth by causes over which they had no control.

Educational level of retarded children's fathers and the reasons ascribed by them for the retardation of their children

Educational level of fathers of such children being taken into consideration it was found that the higher educated group showed an inclination towards putting biological defects as the reason for mental retardation, whereas the uneducated group indicated destiny (God's wishes) as the causative factor of mental retardation. The middle educated group of high school and intermediate status (in higher percentage) were not able to suggest any reason. It may be indicative of the mental strata of the parents effected by their education. Generally the parents were unable to link up cause and effect of mental retardation. The above findings are reflected in the following table.

Income level of retarded children's fathers and the reasons ascribed by them for the retardation of their children

Table 52 shows that the income variation of subjects of study, i.e., the parents of retarded children when taken into consideration, the majority being of the lower income group, showed tendency of ascribing retardation to biological defects and just a little less in the same income group stressed the reasons as God's wishes or results of past *Karma*. The highest income group, however, does not pay so much importance to biological defects.

TABLE 51

Educational level of retarded children's fathers and the reason ascribed by them for the retardation of their children

Educational level of fathers	*God given*	*Fruit of past Karma*	*Biological defect*	*Do not assign any reason*	*Total*
Primary and Junior High School	5	6	10	1	22
High School & Intermediate	3	1	3	5	12
B.A. and M.A.	6	4	13	3	26
Uneducated	9	1	4	1	15
Total	23	12	30	10	75
Percentage	30.67	16	46	13.33	100

TABLE 52

Income level of retarded children's fathers and the reason ascribed by them for the retardation of their children

Income level of fathers (in rupees per month)	*God given*	*Fruit of past Karma*	*Biological defect*	*Do not assign any reason*	*Total*
100-400	18	5	24	6	53
400-800	4	5	5	1	15
800-1200	1	2	1	3	7
Total	23	12	30	10	75
Percentage	30.67	16	46	13.33	100

Occupational level of retarded children's parents and the reasons ascribed by them for the retardation of their children

Within the occupational level, the men in business have tended to stress more on biological defects as the causative factor of mental retardation whereas men in agricultural occupation have put more emphasis on past *Karma.* Normally people in agricultural occupation are linked with the backward means of production and they are away from complexities of urban life. They are filled with superstition and faith of *Karma.* Obviously they are thus liable to find defects with their past *karmas.* The Table is as follows:

TABLE 53

Occupational level of retarded children's parents and the reason ascribed by them for the retardation of their children

Occupation of parents	*God given*	*Fruit of past Karma*	*Biological defect*	*Assign no reason*	*Total*
Business	14	6	20	3	43
Service	9	4	10	4	27
Agriculture	—	2	—	3	5
Total	23	12	30	10	75
Percentage	30.67	16	40	13.33	100

Caste/Community of retarded children's parents and the reasons ascribed by them for the retardation of their children

As Table 59 reflects, caste and community do not in particular indicate any other variation than the number of subjects studied and they are directly proportionate to number of such subjects. Of course, Vaishyas have given out that the cause of mental retardation of their child is the wish of God. But in the case of occupation as shown in the earlier table 'business' has shown

biological defects as a factor in majority of cases of retardation. So it can be derived that Vaishya community of businessmen are more tradition-oriented and other business community people ascribe biological reasons to be the cause of retardation.

From all the variables considered the result is that 30.67% of the subjects of study have given out God's wishes to be the reason for child's retardation whereas 40% have taken biological defect to be the reason for mental retardation. Sixteen per cent have, however, pinned down the reason to be past *Karma* and 13.33% have not been able to assign any reason. So it can be said that almost a similar number have opted for a subjective and an objective cause for retardation.

Search for a Cure

Medical science is advancing so rapidly that many parents hope for a miraculous cure if only they can find exactly the right specialist or the right new treatment. The flurry of enthusiasm which greets the announcement of any drug which is claimed to promote mental growth, is evidence of this hope. No drug, however, has as yet proved at all useful for this purpose. It is highly doubtful that any seriously damaged child will ever be made completely normal.

There are often special sorts of treatment which could help a retarded child to develop the abilities he possesses. Parents frequently seek such opportunities but seldom with success. For example, speech or physical therapy might be of considerable benefit to a retarded child whose development in these areas is significantly behind his general mental level, but his parents would probably find the doors of many speech and physical therapists closed to them. Psychotherapy, too, would often be appropriate for families in which parents and children have formed patterns of interaction which lead to tension and conflict.

But in this part of the country even medical cure of mental retardation is not very satisfactory or abundantly available and like many other areas of scientific development in this field too we are lagging far behind the countries of the West. So the parents of the children are obviously unable to find much help from the medico-assistance in such matters. The parents of the children studied in this work have shown different attitudes with regard to

their faith in curing their child. Their attitudes can be tabled as shown below:

TABLE 54

Belief of parents that the children can be cured through treatment

Parents believe	*Number of parents*	*Percentage*
Can be fully cured	29	38.67
Can be partially cured	38	50.67
Only Divine Charisma can cure	8	10.66
Total	75	100.00

The table shows that the majority believed that their children could be partially cured. Only 38.67% believed that they could be fully cured and only a few of the subjects studied indicated that a Divine Power could make any improvement.

It is pertinent to note here that this investigation was limited to such children as were being treated and educated under something like a proper medico-educational institution. Perhaps a survey of other children not under such care can produce a different result. This is not, however, within the scope of this study and the present author is not in a position to give out a general impression about the parents of the retarded children.

The present study reveals that as most of the parents found positive improvements from such medico-educational care, an important derivation that can be safely made is that, if the environmental condition of the mentally retarded children are improved and made more congenial it may produce good results in such children. Obviously, our country needs a wider net-work of such institutions for providing some relief to this social malady.

Improvement of the Mentally Retarded Children

The mentally retarded children may be born in any type of family or environment, and because of their impaired ability to

learn and work, they demand special care, attention and treatment suited to their intellectual capacity so as to meet the demands of the day-to-day living.

It has been observed that proper care, special education and training help mentally retarded children to grow to their full mental capacities, to learn to conduct essential activities of daily living, gain useful simple knowledge, learn some trade, and sometimes even to become socially and economically independent.

All children regardless of their handicaps are entitled to benefits of education. In accordance with needs and capacities of mentally retarded children a great need arises to provide special education to them. Special education means an education suited to the needs of the individual. To attempt to educate a blind child by giving him an ordinary printed book to read would be useless. To expect a deaf child to hear instructions given in an ordinary classroom would be unreasonable. To expect a seriously retarded or slow-learning child to grasp principles or appreciate experiences that a gifted or normal child of the same age would understand and enjoy, would only contribute to his confusion and despair. Therefore, the need arises for special education for mentally retarded children. How a child will progress is, of course, determined by the extent of his impairment.

TABLE 55

Parents' view regarding the improvement of their children

Parents' observations	*Number of parents*	*Percentage*
Marked improvement	24	32.00
Slight improvement	29	38.67
No improvement	22	29.33
Total	75	100.00

The children in this investigation were from institutions and as discussed earlier under medico-educational care and their parents

not only showed a faith in the possibility of improvement but also marked positive improvement. The views of the parents about the results analysed by them objectively about their children with respect to such improvement can be tabled as above.

Only 29.33% found no improvement, whereas the majority found marked or slight improvement. This further goes on to assert the need of proper institutional care of the child.

Regularity and irregularity of parents regarding visiting the clinics

When it was asked whether parents regularly or irregularly visit the clinic for the treatment of their children, the responses reveal the following data.

TABLE 56

Education of retarded children's fathers and their regularity regarding visits to the clinic

Education	*Regular visits*	*Irregular visits*	*Total*
Primary-Junior High School	10	12	22
High School and Intermediate	6	6	12
Graduates and Post-graduates	—	17	17
Uneducated	5	19	24
Total	21	54	75
Percentage	28	72	100

As stated earlier, this study has shown that parents have found positive results and have faith that their children can be improved to some extent. However, it was also revealed that the parents are quite negligent towards the medical treatment and they often fail to visit the clinics.

TABLE 57

Income of retarded children's parents and their regularity regarding visits to the clinic

Income in rupees (per month)	*Regular visits*	*Irregular visits*	*Total*
100-400	12	41	53
400-800	5	10	15
800-1200	4	3	7
Total	21	54	75
Percentage	28	72	100

TABLE 58

Occupation of retarded children's fathers and their regularity regarding visits to the clinic

Occupation	*Regular visits*	*Irregular visits*	*Total*
Business	10	33	43
Service	11	16	27
Agriculture	—	5	5
Total	21	54	75
Percentage	28	72	100

TABLE 59

Caste/Community of retarded children's parents and their regularity regarding visits to the clinic

Caste/Community	*Regular visits*	*Irregular visits*	*Total*
Brahmin	2	8	10
Kshatriya	4	5	9
Vaishya	11	23	34
Other lower castes	2	13	15
Muslims	—	4	4
Christians	2	1	3
Total	21	54	75
Percentage	28	72	100

After consideration of the education, income, occupation and caste/community variables, findings show that about 72% of parents are not regular in attending the clinic and in all cases the results are similar.

Conclusion

In the present study it has been found that most of the children are from the group of mildly or moderately ratarded children. This was recorded when these children were admitted in the institutions where this study was undertaken. These children are under medical supervision and institutional care. The parents of these children think that their children have been impaired by wishes of God and past *Karma* and almost a similar number have ascribed biological defects as the reason for mental retardation of their children. So the attitude of the parents is not quite definitely analysable for finding the reason. Though this is not a very

important factor of improving the fate of such children it only reveals their attitude. It has been found, however, that the parents believe that their children can improve and most have found positive results.

Whatever may be the subjective or objective feelings of the parents, they are quite indicative of having found a good result. But the study signifies that the parents are not very particular and regular in helping their child as they are quite irregular in attending such clinics. They are negligent towards visiting clinics for cure of their children. It is quite possible that they are more inclined to vocational-educational care of children and not so much particular about medical treatment. Or else being mostly in lower economic strata they are busy in their economic activities and earning their livelihood and have no spare time to visit the clinics regularly. It may be possible that provision of mobile medical treatment to such children may improve matters. This problem being a great social problem, the state may well help in the matter by setting up such mobile clinics.

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8

Case Histories

The following are the case histories of 20 samples of mentally retarded children of the present research work :

Case History No. 1

The boy N 1 aged about 10 years having IQ of 45 is the first child of his parents. His father Mr. J.C. is a graduate. He is a businessman doing business of carpet trade and is generally away from his home. The mother is with the child and is not educated. N 1 has three sisters and two brothers. The education of the parents or the sibling order of the child cannot be found to have any bearing on the condition of the child. Of course, history of disorder in the family line can be found in the case, and occupation of the father and such other reasons may be contributory factors for the mental retardation of the child. The grandfather of the child was a mental patient at his later age and the family migrated from village to city. Theirs is hardly a good family life because the husband is always busy at his profession; wife lives with the children.

Although the father of N 1 is a businessman yet he earns very little and hence the financial condition of the family is very poor. It is a nuclear family. Father is always busy outside and whenever he comes home weekly, he is disturbed seeing the state of affairs. He is not a cultured and refined man and as his wife demands money from him he starts abusing her; sometimes beats her and his children severely. He drinks a lot. Whatever he earns, most of the amount is spent for purchasing liquor. The poor retarded boy N 1 becomes the scapegoat for everyone, as both the spouses (parents of N 1) take their revenge by beating and abusing this child who does not clearly understand the reason of the quarrel at all.

Case History No. 2

N 2 (a sample of the present study) is a mentally retarded girl of 14 years and unfortunately she is the only child of her parents. Father of N 2 was jobless for sometime just after his marriage. So he and his wife both were dependent on the joint family. They wanted a late child, but N 2's mother became pregnant. She used some cheap medicines for abortion. Ultimately she did not succeed and the newly born child became mentally retarded. The major cause of mental retardation in this case seems to be the drugs used for abortion by the parents of N 2.

N 2 is the only child of her parents who live in a joint family. Nobody treats her properly in the family. N 2's father is still jobless and the family is well-to-do, as her father's younger brothers (two in number) earn handsome salary and they have six children in total. All other children are normal and are loved by their grand-parents too, excepting the poor girl N 2. She is the victim of the poor condition of her parents. She does not get proper food, dresses and proper care. She has never been admitted to any school before the age of 13 years. Only this year her maternal uncle got her admitted in the mentally retarded school.

Case History No. 3

In the present work it has been found that N 3 and N 4 are two children belonging to the same family aged 13 and 7 years respectively. They are the first and third children of their parents. Both are retarded. The IQ of N 3 is 45 and that of N 4 60. They live with their parents. They belong to Vaishya family. In the family generally there is very low level of education. Though the father has been able to get primary education, all others are illiterate. The father aged 45 years has a grocery shop and even the retarded child N 4 of such a low age sometimes attends to shop duties. Obviously the parents are not so worried about either case of mental retardation. They are in all 6 brothers and sisters and father shows little care for education of his children. Of course, he wants his children to get developed to some state of mind that they may be able to help in his business. Their mother is an illiterate lady and she keeps herself aloof from the whole affair and hardly shows any interest. They live in a joint family and are in a poorer strata of society and always busy to make both ends meet.

There is always some quarrel in the family and the family life is disturbed.

In this family it seems that nobody is much worried about the retardation of two children. A social worker finally brought the two children in the Child Guidance Clinic and got them examined. That was only the first and last visit of the children in the clinic. Their parents never turned up and in spite of repeated requests of the social workers the parents never cared for these poor children. The retarded child whose age is 13 years and IQ 45, obeys the orders of his younger siblings who often beat him and snatches the toys, etc. from him. N 4 is a little boy of 7 years who also commands his elder brother N 3, though he too is retarded.

Case History No. 4

N 5 is a mentally retarded child of aged 9, whose father is a trader dealing in carpets. Most of the time he is busy with his occupation but earns little money to satisfy the needs of his family members. N 5 is a member of a joint family. It is a crowded joint family having 31 members including children. The mother of N 5 has to perform several delicate roles as a wife, daughter-in-law, sister-in-law and above all the role of "*grihlaxmi*". Doing twenty-four hours service to everyone in the joint family is her sacred duty, but committing even insignificant human mistakes is not pardonable. Everyone demands too much from her but they have little to offer in return. The father of N 5 is also a problem for her. He is jealous of the attention which the wife gives to her children, especially in case of N 5 and feels that he is largely shut out from his wife's affection. The in-laws and husband's undue criticism played havoc and the life of both the partners became tragic. Mental health history of the family is healthy.

Case History No. 5

N 6 is a mentally retarded child who belongs to the family of a business community. His father has three other brothers living with him. The eldest of them has a shop whereas the father of the child, being educated up to graduate standard, is employed in a factory as a clerk (accounts). But he also after his duties mainly spends his time in the shop which is the shop of general merchandise. This shop is the main source of income for the family on

which the whole family depends. The other two brothers are particularly doing nothing. This family belongs to the lower income group. There is always some quarrel which affects even the parents of N 6. They are generally quarrelling over petty issues which become very important for them. The mother of N 6 tries and exerts pressure on her husband for partition which the father of N 6 do not feel to keen about as he is afraid that the splitting up of business may not be economically practicable for him. Such being the conditions and because of the many children in the family there is often big quarrels. It is a peculiar joint family existing in spite of continual tension. N 6 has got 3 younger brothers. All are mentally and physically normal. N 6's grandfather loves him very much but he has got very little voice in the family at the age of 70 years. He is totally dependent economically and physically.

Case History No. 6

N 7 is a child of 12 years and is the second son of his parents and has taken birth in close proximity. Just at the time of his birth his father secured employment. Before that he was unemployed and had a big family at the time when the mother of N 7 became pregnant. The tradition-oriented system of *parda* is practised and the mother has to be busy with household activities; being a typical family-bride with too many in-laws in whose presence N 7's mother cannot speak freely to her husband even during the day. Thus she cannot fulfil her romantic desires. N 7's father being very busy in family affairs and in his occupation, considers his children and his nephews and nieces to be the members of the same family. He has very little time to show affection to his wife. N 7's mother does not like her husband to involve himself too much with the other children of the family but due to her submissive and polite nature she cannot dare speak out. This in turn has affected her attitude and made her strict towards her own son. However, before she conceived the second time, she developed a dislike for motherhood and as such made no mental preparation for the motherhood of this second child. All this has been revealed by other members of the family in absence of N 7's mother. Although she is a lady of good temperament as she behaves nicely with other children of the family somehow or the other she has become extra-strict with this

second child. Naturally the child has also shown a sense of fear at early childhood for his mother.

This case history reveals that the retarded child is unwanted by his mother who was very strict and rude towards the child in his early childhood. No doubt, N 7 has been loved by his father and other members of his family but his want of love and affection from his mother has not been fulfilled.

Case History No. 7

N 8 is a child of ten years. Both the parents are educated. They have no economic problem and are a nuclear family. He is the first child and probably in an attempt to avoid conception so early the mother of N 8 had taken drugs in her initial natal stage. As the drugs failed the child was born. The attitude of the father is that he hardly takes interest in the child and the mother also does not show much of interest as is expected from her. Also the child, in his infancy, had been left with a maid-servant who obviously has no other interest except professional work. Such a situation of having been reared up by a maid-servant sometimes continues for days together when the parents are out.

The maid-servant who is an old lady of rural habits and is still working, revealed to the investigator on her request that she at times had given some drugs (i.e. opium) to keep the child asleep while she had to attend to other duties in the absence of the parents. Now N 8 is in the hostel of a mentally retarded school. Being the only child of his parents, the parents now show a sense of repentance, for such negligence shown by them towards the child at his early age.

They now often offer prayers in the temples, visit *fakirs*, *sadhus* for their blessings in the hope their child may be cured.

Case History No. 8

N 9 is a moderately retarded child of 12 years. The mother had never sought medical advice because she and the father both believed N 9 to be God's punishment for being born long before the marriage, an illegitimate boy. In one way or another, the parents feel that the blame for their child's handicap rests with them. As a consequence of her guilt, the mother had been unable to discipline the boy. He had not been toilet trained; he grabbed food from

the plates of others and he is disobedient and destructive. A meeting with the concerned doctor revealed that the child was the victim of a progressive carbohydrate storage disease which eventually would be fatal. Father vigorously blames his wife for the retardation of the boy.

The parents were married long back, i.e., over 15 years ago. N 9 was the first and the last issue of their parents. They do not want any more child and they adopt all precautionary measures to avoid conception. The peculiarity is that they blame themselves as they were in love with each other before their marriage and conceived the baby before formal marriage. Because of this superstitious belief they neither can seek the help of physicians or psychiatrists nor visit religious places with their guilt-ridden consciences.

It seems that the parents themselves are not quite normal. But otherwise they are very well behaved and N 9's father is very social and is a clerk in the department of the food corporation.

Case History No. 9

N 10 is the nine-year-old boy of two highly intelligent parents. His father is a good businessman with post-graduation degree, and his elder brother and younger sisters are likewise exceedingly bright. N 10, on the other hand, was of only average intelligence. His school work too, was average in marked contrast to that of his siblings. At home he was quiet and meek but given to episodes of weeping and locking himself in his bedroom. Despairing of their son's slowness, the parents placed him in a private school in which most of the children were like his siblings much brigther than N 10. Ostracized by his classmates and to some extent by his family, N 10 became disobedient and ill-tempered, generating in his parents further attempts to 'improve' him. The parents admit that their child N 10 has to face the same problems of those of a retarded child although he is not retarded because his achievement is less than their expectation and he differs in his interests from the rest of the family. At present the retarded child becomes the focus of all past wrong doings of which the parents are now feeling ashamed.

2 History No. 10

N 11 is the son of a wealthy Hindu Brahmin family. The cture of the family is nuclear. The father is a reputed doctor mother, a graduate. Unfortunately, N 11 is the only son of his nts. At the time of marriage the age of the father was 28 and of the mother 27 years. Both of his parents knew each other a pretty long time (about five years) and ultimately they ried with the consent of their parents.

N 11's delivery was perfectly normal. He had no serious child- d disease. But he talked and walked later than the usual time. is extremely disobedient, aggressive, obstinate and fearless. There nurse to look after him at all times. When he was 8 years old, vas admitted to a private school but due to his ill behaviour and rded intellectual development he was unable to compete with his smates. He was turned out from the school due to acute avioural problems. At 9 years of age he was admitted to the d guidance clinic. There it was detected that his IQ level was w normal, i.e., he had an IQ of 60; the retardation was mild.

The marital relations of his parents were found to be healthy. y do not want to send the child to an institution or hostel. ing the child at home has made the parents more aware in r evaluation and proper handling of the child. It is to be noted that against the general rule, the parents do not feel guilty and are not much ashamed of their child. They have deputed a se for the constant supervision of the child.

The child constantly creates a problem with his peer group as s always aggressive, non-cooperative and wants to dominate r the other children, though he is retarded. It reveals that the d gets much protection and affection from his parents.

After much effort made by the parents, the nurse and child dance clinic, it has been found that child can only write the di alphabet and nothing more at this stage of 9 years 10 nths.

According to the doctors the child's is a case of brain-injury.

e History No. 11

N 12 is a retarded child aged 12 years. His IQ is 50. He ngs to a poor family. The family is joint in nature. His her died when he was only 2 years old. Father works hard.

He returns home late in the night and is addicted to country liquor and gambling. Although the father of N 12 drinks a lot and is a regular gambler, still he is a simple and honest man. He tries his level best to earn money and keep his sons and daughters happy. N 12 has got one younger sister aged 11 years and 2 elder brothers of 17 years and 21 years respectively. The other siblings are of average intelligence.

Not a single case of mental retardation or mental illness could be found in the family history. The father of the child is very much frustrated and disappointed with N 12's condition. The socio-economic status of the family is poor; the other two brothers are already employed in a soap factory, each of them earning about Rs 100 per month. But N 12 at the age of 12 years behaves like a child of 4 or 5 years. His father seems to accept the fact that N 12 can never earn his livelihood and will be always dependent. He feels very much disturbed when he thinks about the future of the child especially after his death.

There are other members too in the family. N 12's father has two more brothers—one is elder to him and the other is younger to him. They are having 12 children in all. The grandfather and grandmother of N 12 also stay in the same house. The house produces a very gloomy picture. There are only two living rooms and one verandah without any kitchen, bathroom and closed toilet space. It is a very quarrelsome family. The other siblings always tease N 12. They beat him and sometimes they become furious with this child. Practically there is none in the family to protect the child and behave affectionately with him. Only the grandmother is affectionate but she is a lady of 90 years and is almost an invalid.

Generally the child is obedient, well behaved but he is always afraid of his siblings, mainly of his youngers.

The father of N 12 believes that only a miracle can cure his child; otherwise he has lost all hopes. He got him admitted in the mentally retarded school (Sample Spectrum) where N 12 gets free education and training. According to the teachers of the institution, N 12 is a student of class one for two years. They could not specify any progress in his achievement; otherwise the child is docile, introvert and obeys the order of elders.

Doctors are of the opinion that it is a case of convulsion which caused brain damage in the child. The child has frequent attacks of epilepsy.

A mentally retarded child needs love, security and stimulation even more than a normal child which was totally lacking in the family.

Case History No. 12

N 13 is a 7-year-old mentally retarded boy with an IQ 45. He is a student of standard I of the mentally retarded school (Sample Spectrum). At the age of 5 years he showed restlessness and abnormal behaviour. So the parents sent him to the school.

The father N 13 is a business man, earning about Rs 800 per month. Mother is educated up to class X and is unemployed. N 13's parents have 2 more sons—one is aged 4 years and the other 2 years. The parents have been married for 8 years.

When the parents' reactions to mental retardation of their child was analysed, it was found that at first they could not believe that the child was retarded. The discovery came as a tremendous shock. But after some time they had to accept the fact when at the age of 5 years N 12 was analysed by a psychiatrist who advised them to get him admitted in the Special School.

The parents often quarrel with each other and blame themselves for the child's illness. Just after their marriage N 13's mother conceived and they tried for abortion but the attempt was unsuccessful. She delivered N 13 normally after one year of her marriage.

The structure of the family is nuclear. There are only 5 members in the family—3 children and parents. It is a well-to-do family. There is not a single case of mental abnormality in the whole of the traceable family history.

Doctors suspect that too much drugs taken for abortion, proved harmful for the brain of the child. Here the parents of the child admit that the doctor helped a lot—informed them about the child's condition, assisted them morally and practically and also showed them a proper way to handle the child.

The other siblings of N 13 are very young. So their behaviour orientation towards N 13 is not really meaningful. Parents are affectionate towards him. But one thing in the family seems

a bit disturbing. Both the parents care much for N 13 and practically the other two children are neglected. Parents are over-protective and over emotional about N 13. Financially the family is much affected by the presence of this child. Parents think that the education and care facilities they are giving to N 13 are inadequate. At the same time, to some extent, they are satisfied by the achievement of the Special School where they have admitted their child.

N 13, sometimes, is very aggressive. He demands too much from his parents. He is destructive in nature. The other children in his peer group are afraid of him, and they obey his commands.

Case History No. 13

N 13 is a girl of 8 years having an IQ of 70. Her father is a doctor and mother a teacher in a government school. She has 3 brothers—one younger to her aged 5 years and two elder, aged 13 and 15 years respectively. The eldest brother of N 14 has just appeared for junior cambridge examination. The second brother is a student of standard VIII in the Convent School. The youngest brother is not yet at school. The other siblings of N 14 are all normal. N 14 was admitted in the mentally retarded school 2 years back at the age of 6. The parents observed some abnormal behaviour in N 14 and the father, being a doctor, immediately got her admitted in the Special School.

The structure of the family is nuclear. All the members of the family have accepted the child, but sometimes they are over-protective. The psychological climate of the home is healthy.

N 14 is restless and aggressive sometimes, but most of the times she is calm and quite. She does for moments regret her misbehaviour, apologize and make promises, and is sincere in what she says.

The parents are educated but feel somewhat guilty. The mother of N14 being in government service had been transferred to some other place just after the birth of N 14. So she had to leave her when she was only 2 months old in the hands of the nurse. But at present they are living together as the mother of N 14 somehow managed to come back to her husband's house. The environment of the family seems to be healthy.

Case History No. 14

N 15 is a boy of 10 years with an IQ 45 and belongs to a very well-to-do family. He is the first case of mental retardation in the last four generations in this family. N 15's younger brother, who is the only other issue of his parents is perfectly normal. N 15's behaviour is very calm and quiet. He does not speak to anyone and if something goes against his wishes he cries like a small child of about 2 years. In this case the drugs seem to have played a great role in his retardation. When N 15's mother was pregnant at the same time she was preparing for her university examination. As generally during pregnancies drowsiness is not uncommon, she used to take anti-sleeping pills to keep her awake so that she could study. The large dosage of these pills and overstrain due to study might have affected the development of the foetus. Also, as the mother told the present author, she fared badly in one paper because she could not study properly. Thus she was mentally disturbed for a very long time and formed the opinion that this foetus was the main hindrance in her study.

The mother explained frankly that as she was married at an early age against her wishes and, as it was her desire from the very beginning of her life to become a professor of an university, she was very keen about her studies. She further stated that due to this reason she never cared for the child after its birth also. All these factors reveal that the drugs and neglect of the child by the mother in the absence of any other elderly member in the family, caused substantial damage to this boy.

Case History No. 15

N 16, a girl of 13 years, is severely retarded and also is physiologically handicapped. She cannot speak properly, or even walk properly as one of her legs is affected with polio. One of her hands is also short which is mainly due to the fact that the child was absolutely neglected by the parents particularly by the mother. She was not properly vaccinated due to which she got the attack of polio. She was always left all alone at home at the mercy of the servants. She fell down one day from the roof and got her arm fractured. After the operation her arm was found to be slightly shorter.

Lengthy discussions with the mother revealed the following facts. The mother was married when she was an undergraduate into a family which seemed to be very polished but in fact, was not so. Also there was a vast difference of age between husband and wife, i.e., about 18 years. The father of the child was ill-tempered at home. He was addicted to drinking too much, and thus, would torture his wife in the nights into a state of semi-consciousness. Thereafter, N 16's mother decided to do some service and to establish herself separately. The mental state of the mother was always much disturbed in the critical stages of her pregnancy and also in these critical stages she got injuries due to the torture of her husband. Due to all these reasons the girl was born premature, i.e., after 7 months of pregnancy. The mother anxious to study and provide for herself, neglected the care of the infant. Although N 16 had a grandmother, she was more devoted towards religion and left her to the care of servants when the parents were away.

The mother later disclosed that she suspected that the servants frequently drugged the baby to induce sleep since whenever she herself, returned in the evening she found the child sleeping.

Case History No. 16

N 17 is a boy of 13 years. His IQ is 45. He has got one elder brother of 21 years and one elder sister of 17 years. His father's income is Rs 800 per month. N 17 belongs to a joint family. His physical development is normal but he is a bit shy in nature. Environment and living standard of his family is fairly good. Every member of his family is well educated and cultured and all the members of the family love N 17. He is the third and the youngest son of his parents. Delivery was normal. At the age of 4 when his parents and other elderly members of the family found that he couldn't speak properly or dress properly and did not possess the qualities of a child of 4 years, they took him to the hospital. Doctors diagnosed him as a patient of mental retardation. Later only at the age of 13 years, he started dressing himself without seeking help. He is very neat and clean and very much conscious about physical cleanliness. But the peculiarity is this that he refuses to wear woollen clothes even in the coldest days of winter.

At the time when he was taken for admission to the G.C.M. School, alongwith the parents of N 17, his sister-in-law, uncle, maternal uncle and even the old lady of 55 years (grandmother of N 17) went with him. His grandmother loves him a lot and she always over-protected him. His grandfather around sixty, is a lawyer and still practises.

N 17 has been admitted to the hostel and his uncle and grandfather often visit him in the hostel. Most of the members of the family are of the opinion that grandmother's over-protection and too much affection for this child caused retardation.

Internal relationships of all the members are very healthy. They have their own multistoried house. All the members of the family are quite concerned about N 17. Elderly members are worried about his future. They are ready to spend any amount of money for the improvement of this child.

In the institution the teachers and social workers behave strictly with this child in order to neutralise the effects of over-protection.

Case History No. 17

N 18 is a girl of 11 years. Her IQ is 65. Her mother's age is 45 and father's 50 years. Monthly income of her family is Rs 500 per month. She is the sixth issue of her parents. She is very weak and she has some regard only for her mother. Otherwise, she has no love, affection and regard for any other member of her family, but she behaves very affectionately with the children of her family. At the age of 32 N 18's mother delivered her first issue and at present she has got 7 children. The other siblings of N 18 do not behave properly with her. There is no abnormal mental health history in the family.

The father of N 18 has agricultural land from which they get all the necessary food. N 18's mother is a very superstitious lady and almost every day visits temples and prays for her retarded daughter. Often monks and *sadhus* come to the house and take undue advantage of her superstitious attitude. She does not visit the clinics or doctors regularly for the treatment of her daughter. Neither does she attend the meetings of the guardians organised by the institution where N 18 is admitted, but regularly worships god and goddesses as a result of which she becomes the victim of frauds. The father of N 18 is much annoyed with this behaviour

of his wife, but the mother dominates the whole family and he surrenders himself in order to avoid unpleasantness.

Case History No. 18

N 19 is a mentally retarded boy having the IQ 60. His age is 14 years. His father is the eldest son of the family and has two younger sisters and 3 younger brothers. N 19's grandfather is retired. Thus the whole financial burden is on N 19's parents.

When his mother was in the second stage of first pregnancy, N 19's father lost his job which left them in a critical financial position. At the same time the father of N 19 was to marry off his sister. The mother thus had to face acute mental agony which could have had substantial impact on the development of the foetus.

Further, after the birth of the child, the financial condition worsened and the mother was also forced to do some job. Due to this the child was not looked after properly as his grandmother and aunties were also busy in doing other jobs.

Later things improved and when N 19 was 1½ years old his father became a Class I Officer. Preoccupations outside kept both father and mother always from home and the child was left all alone with the servants. All his other siblings who took birth after his father became Class I Officer are normal.

In this case tense mental condition of the mother at the time of pregnancy and lack of affection and proper care after birth, seem to be the probable reasons for the mental retardation of this child.

Case History No. 19

N 20 is a boy of 10 years. His IQ is 45. He is the youngest child. His parents are putting up in a place where traditional believes are still in vogue. When N 20's mother was pregnant she fell ill, and the family members instead of taking her to a doctor took her to *ojhas* (people who have control over spirits) to get her cured. The witch-doctor adopted all kinds of ritualistic methods, including beating which they consider one of the important weapons of removing the effects of the spirits from the body. In spite of repeated protests from the mother the *ojha* never left her and made her sit before a fire for a long time in hot summer. Due

to all these, mental state of the mother was very disturbed for a pretty long time and as she has reported, she became practically mad and at times beat her stomach with her own hands. Thus, the foetus was disturbed hindering normal development and the doctors were forced to do premature delivery.

All other siblings of N 20 are normal. His parents are also perfectly normal but one of his late great fathers was neurotic. The socio-economic status of N 20's family is poor and as his father is away in a distant town, N 20's grand-parents have more domination in the family. They still do not believe in present techniques. The mother of N 20 has practically no voice in the house. It is a joint family consisting of 40 members all depending on agriculture income excepting the father of N 20 who works in a factory.

It seems that poor socio-economic condition combined with superstitious rural attitude of the family has caused post-natal damage which, in turn, produced a mentally retarded child. N 20 has got 3 younger sisters who are all of average intelligence.

9

Conclusion

During the past twenty years our society has shown an increasing concern with mental illness as a major social problem. For segments of the population this concern was stimulated by an increased awareness of the large numbers of mentally ill people, for others, "by the poignant autobiographical descriptions of subjective distress given by the mentally ill"[1]; and for still others "by a fear of the actual and possible costs, both direct and indirect of mental illness to the social system."[2]

Medical and social sciences have made a substantial beginning in this direction. Rapidly growing interest in the problem of mental retardation is producing a growing accumulation of data on the general conditions with which mental retardation is associated. Nevertheless, despite the recent progress made by the medical science in identifying causes and developing preventive action for these specific causes, the hard fact is that the dramatic results flowing from new knowledge as yet apply only to part of the cases which can be specifically diagnosed and to only a small fraction of the total causes of mental retardation. A variety of unfavourable factors such as pre-natal care, poor nutrition, deficient post-natal care may produce damage to the brain which cannot be generally measured with present techniques but which will constitute a drag on neurological development. Clearly, however, the incidence of mental retardation is heavily correlated with a lack of proper maternal and pre-natal health care, which in turn is closely associated with the unfavourable socio-economic status of families or whole neighbourhoods or groups in the population.

It was recognized at the inception of the surveys that there are two broad areas of study which relate to the causation of mental subnormality. One of these areas of study has to do with those factors which produce anatomical or chemical abnormalities of the nervous system and thus interfere with the ability of the brain. The other is concerned with the study of cultural and environmental factors, which, through the establishment of unhealthy or inadequate patterns of intellectual response may prevent the optimum functioning of the mind in a person whose nervous system is basically capable of normal activity.

The main subject of the researcher of this investigation has been to point out the necessity for more adequate knowledge of how the retardate's life situations in the family, the school and the community generally react to him and how these reactions might be modified to produce an environment that would contribute to his optimal development. To date, most of the research attention has been on the retardates' own qualities and capabilities as they may effect his chances in life for a reasonably satisfactory adjustment. This type of research should, of course, continue but be balanced by an equally skilful and perspective attack on the life situation in which the retardate interacts and develops.

The review of available research literature related to the problems of mental retardation both in India and foreign countries, indicates that no comparative studies were conducted on family conditions of mentally retarded and normal children.

Samples of the present study are of two types: (i) the 75 mentally retarded children and (ii) 75 normal children of the same age group. Matching variables among the two groups taken were the same age group of both groups of children, the age group of parents (being almost same) for both normal and retarded children and the income level of both groups of samples (being almost the same). Samples of mentally retarded children have been collected from the sources mentioned in the second chapter. Samples of normal children have been collected from the different localities of the Varanasi city, keeping in view that matching variables in both the groups were constant. Sampling has thus been done on the basis of quota sampling.

Two types of data have been collected—primary as well as secondary. Major survey instruments were two sets of schedules—

one set for measuring the family conditions of the mentally retarded children and the other set for measuring the family conditions of normal children.

Summary of Chapters

The first chapter begins with the theoretical aspect of the problem of mental retardation, historical background of the concept of mental retardation and the present and basic knowledge of the problem. Different causative or stimulating factors are discussed which create or influence mental retardation.

In the next chapter the theoretical as well as applied value of the problem have been dealt with. Very little research has been conducted in India regarding social background aspect of mental condition. Attitude of the State Government is also not very encouraging. The present research is a comparative study and it has its own universe. Three institutions were selected for the field work and the samples of mentally retarded children were collected from these three sources. Both primary and secondary data were collected. The principal instruments for investigation were two sets of schedules mentioned earlier.

In the third chapter the composition of the family background of normal and mentally retarded children has been discussed. It has been found that most of the retarded children are of low economic status. Data reveal that high frequency of mental retardation is found in first born children. Physiological conditions of parents have no distinctive effect on their offsprings or on the mentally retarded child.

In chapter four, marital adjustment of the parents of retarded and normal children are analysed. Marital relationship among the parents of retarded children in major numbers were found to be unhealthy as compared to that of normal children. The line of results is that people with lower income and some education occupied full-time in business, find a contradiction between their ideas and realities. This obviously might be a result of their not getting a sense of satisfaction from their spouses.

Chapter five, thereafter, takes up the parent-child relationship. Unwantedness and rejection are found markedly in case of the mentally retarded children. It has been also found that majority of parents of retarded children have a punitive attitude towards the child.

Chapter six deals with the behavioural interaction between the mentally retarded children and other members of the family. Social behaviour of mentally retarded children and their behaviour interaction with other members of the family and vice versa could not be found to be of great significance. The retarded children are afraid of their elder siblings but are affectionate to their youngers.

Chapter seven discusses some points of investigations regarding medical supervision of retarded children. Attitude of parents regarding the cause of retardation of their offsprings is not quite definitely analysable. Some parents believe that their children have been impaired by the wish of God and past *Karma* and others hold the opinion that biological defects cause mental retardation in their children. But the parents are not very particular in getting prompt medical care for their children.

Chapter eight discusses nineteen case histories of 20 mentally retarded children (of the Sample Spectrum).

And the present chapter which is the concluding chapter, provides a short summary of all the chapters and the hypotheses are verified.

Validation of Hypotheses

The hypotheses were tested empirically. This report is organised around six hypotheses that were formulated explicitly and tested directly.

Hypothesis No. 1

Prevalence of mental retardation is inversely related to the socio-economic status. Findings confirm this hypothesis in the third chapter of this work and the fact that poor socio-economic conditions correspond with mental retardation of the children. Findings show that 70.66% of mentally retarded children belong to the families whose monthly income ranges between Rs 100-400 and only 9.33% of mentally retarded children's family earn Rs 800-1200 per month. Earlier studies in this field confirms the validation of this hypothesis. The study by Passamanick (1959)[3] and studies by Baired and Scott[4] reveal the same findings. Based upon the remarks on the data it can be concluded that hypothesis No. 1 is true. Stated in different terms a distinct

inverse relationship does exist between social class and mental retardation.

Hypothesis No. 2

That the marital status of the parents of retarded children are not healthy as compared to the marital status of the parents of normal children, is also verified by the findings. The research indicates that most of the families of retarded children are joint in nature and these joint families are full of tensions arising out of economic and occupational hardships, cultural differences, differences in social status, matters of ill health and interference of in-laws. The marital life of retarded children's parents is almost a failure in terms of adjustment. The negative adjustment seems to be high among them. The figures also tell a story of marital failure which seems to be quite meaningfully related with the phenomenon of mental retardation. In spite of the fact that the marital relationship is effected by the tensions of the joint families other reasons too affect the marital relationship such as, in connection with the idea of developmental stages in social relations of the retardate. The parents of the mentally retarded children go through some kind of developmental sequence in reaching a full acceptance of their particular identities as parents of a retarded child. They feel self-pity, guilt and resentment and thus they blame and doubt each other.

Hypothesis No. 3

Delinquency and mental retardation are frequent. Regarding this hypothesis the present author finds no positive or even negative reply by the parents as well as from the authorities of the institutions where these retarded children are admitted. Keeping in view some of the previous studies on the present subject this hypothesis was tentatively formulated. But the analysis of the present work demonstrates that mental retardation is neither the specific cause nor the outstanding factor in crime and delinquency, and this view is supported by more recent psychological evidences. It may be the fact that delinquent mentally retarded children are not admitted in these schools but are kept in the reformatory schools and that is the reason the present author could not find such cases in her sample spectrum. Thus, the above hypothesis could not be verified.

Hypothesis No. 4

Most of the mentally retarded children are unwanted and rejected by their parents. This hypothesis can be tested by the validity of the collected data. Unwantedness is generated by many factors, e.g., attempt of abortion, unpreparedness for parenthood, neglect of subsistence needs, administration of drugs for keeping the child asleep in the nights. Of the total sample collected 73.33% retarded children were found to be unwanted and hence rejected by their parents whereas in case of normal children only 2.67% were of such type. The present hypothesis is verified. The study by Mary Woodward[5] and Clarke and Clarke[6] found that the retarded show the ill-effects of unwantedness, rejecting homes and tension-ridden environments.

Hypothesis No. 5

Quarrelsome and unhappy joint families help in bringing about mental retardation in the child. This hypothesis is also very well verified. In case of mentally retarded children the data reflects that 65.33% of such families are joint in nature whereas in normal children 24% of the families investigated were joint in nature. These joint families have been producing a very gloomy picture where members of the family develop different interests by virtue of their roles in various secondary groups. The tensions in these families mostly arise out of economical and occupational situations, cultural differences, etc.

All kinds of resources—financial, emotional and spatial must be divided into smaller amounts in large joint families especially in the lower socio-economic classes, adverse physical conditions may be made even when many family members must share a meagre subsistence. Joint families are usually large having many members.

Supporting the validation of the present hypothesis an excellent review of work published in 1955 has been presented by Anastasi,[7] who cites many reports of a negative relationship between family size and the intelligence of the child.

Hypothesis No. 6

Premature deaths of one or both the parents is found in most of the cases of mentally retarded children in comparison to normal

children. This hypothesis too is verified. Data reveal that in case of normal children premature death of one of the parents or both is only 1.33% whereas, in cases of retarded children this percentage increases to the extent of 30.67%. In case of premature death of parents in the family, it is a well known fact that interpersonal relationship between the parents and the child (especially with mother) is a very important variable. Deprivation in the maternal relationship accompanied by a reduction in sensory stimulation and the common result is intellectual retardation. Even brief periods of such deprivation can rather profoundly disturb intellectual functioning (T.H. Scott *et al.*).[8]

New Findings

In the present work two main points have been found which were quite interesting and unexpected.

Caste/cultural group effect on mental retardation

When caste/cultural group of mentally retarded children is analysed, it has been found that mostly they belong to Vaishya caste having lower income level, the children acquiring business tactics from the family ethos. It has been found that this caste group is isolated, crazy after money, unmindful of higher standards and pursuits of life, earns but fails to spend. Caste endogamy practice makes the probability of retardation still higher.

Sibling Order and Mental Retardation

Sibling order is one of the important factors of mental retardation, viewed by different workers in different fields. Usually it is the later siblings who are found to be mentally retarded, but the present findings do not correspond to this commonly held viewpoint. Of the total samples of 75 children, 27 children were first-born, 18 second-born and 11 third-born. The high frequency of cases of mental retardation is found in first-born. Generally it is said that there is an increased risk of maldevelopment after the third of fourth pregnancy, and some studies have indicated an increased risk with the first (Masland 1958).[9] But the present study does not conform to this view. Studies like Masland's may indicate some sort of physiological process, but it should not be forgotten that no cause and effect sequence has yet been clearly demonstrated. Research in this area

is complicated by the fact that birth order, family size, age of parents and socio-economic factors are closely interrelated.

Sex and Mental Retardation

As discussed earlier, the field of this study are institutions for mentally retarded children and samples have been collected from a research project sponsored by US Government of Health Education and Welfare under School of Social Work, Kashi Vidyapith and GCM School of Mentally Retarded Children. Samples so collected were 75 mentally retarded children. Of them only 4 were females and the rest male children. One of the reasons might be that parents were not very much inclined to put their female children in the institution. The research project scheme undertaken by the School of Social Work, Kashi Vidyapith has not covered a single female child. When the social worker of the research project was asked the reasons for not taking any female child into consideration in the project, the social worker explained that such female children posed obvious difficulties. They could not be studied especially during the period of menstrual cycle because of their inability to care for themselves. Hence the variation of sex for the samples collected could not be well studied in this research work.

On the whole when one analyses all the family conditions of the families of normal children and compares it to that of the retarded children's families, the findings definitely reflect that mental retardation is associated with family conditions.

In the present complex structure of the society in an urban context, people feel that the joint family is a curse. Yet in most cases of retarded children they belong to joint families. Almost each sample of this work belongs to such joint families where tension, quarrels, separation, rejection, step-relations and unwantedness exist. Poor socio-economic conditions associated with the disgusted attitude of parents who feel unsatisfied with their livelihood and think their intelligence is being prostituted, are not in a proper psychological frame of mind to enjoy the social relationship which a family brings. There arises a conflict between his ideals and practices which may easily be a source of friction.

In such joint families when marital adjustment between the parents is analysed the findings project that the romantic

expectations of the partners at the time they married were frustrated by the unromantic realities of the marital situation. The marital adjustment between the parents is of profound significance in determining their offsprings' attitudes and for their mental and social development. Maladjusted marital life in the long run creates unwantedness, rejection and maternal or fraternal deprivation.

Although in the present work, parents of retarded children have been found to believe that their children should get proper medical care, they are quite irregular in attending such clinics. They are rather negligent about a systematic and regular treatment of their handicapped children.

Hence it can be concluded that the findings analysed reveal that such handicapped children belong to *handicapped* families. The new experiences, new stimuli, new associations the child meets within such family environment aid in its mental disbalance and anti-social personality development. The need for recognition is satisfied through the role the child plays in the family, the attention he secures, the status he occupies, the approvals he gets therein, which have been seldom found in such families.

Although most of the family conditions leading to mental retardation is fragmentary, speculative and difficult to interpret, still it seems abundantly clear that some circumstances are more favourable than others, that while most of the children grow up in situations which are on the whole conducive to their intellectual growth, others live in situations which retard or stop development in this sphere.

The present book, from many directions, attempts to throw light into the deep shadows of the present complex problem of mental retardation. This work from field surveys and other sources, strongly suggests that a variety of complex and interrelated factors in this category are definitely associated with the prevalence of mental retardation.

Whatever the causes, the failure of mentally retarded individuals to adjust successfully to social and economic conditions of our society constitutes a severe and growing handicap for the individual, for his family and for the society. Moreover, as our competitive society becomes more complex and fast moving, the demands for intellectual capacity and for adaptability increase.

Thus, in an age of automation individuals with minimal skills and abilities become doubly handicapped. Not only do they face an increasingly competitive society, but hampered as they are, they must keep pace with people of increasingly higher capacities. Thus they become more easily submerged by the vicissitudes which others can surmount. So, much of the long road to the full understanding of the complex phenomena involved lies ahead, and indeed, is not clearly defined as to the directions it may lead.

From these basic considerations the fundamental strategy to face mental retardation takes shape. Because its causes are complex, the battle against mental retardation will have to be "broad spectrum" in character. We must act on many fronts against the root problems in the social, economic and cultural environment which nourish the specific cause and seem to have a major and direct causative influence of their own.

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